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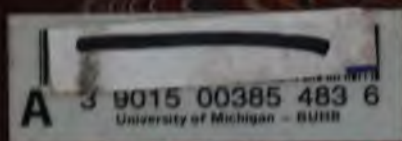
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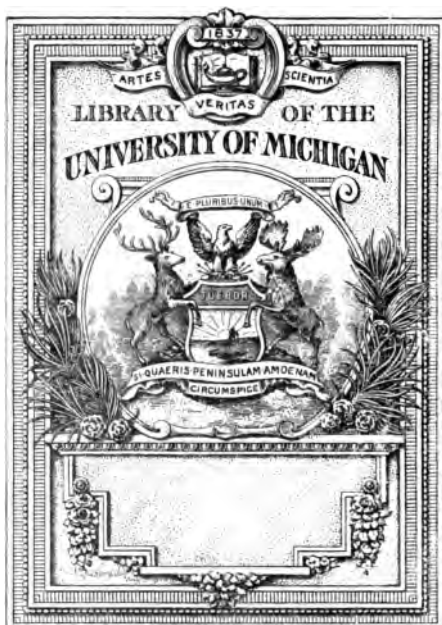
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AMERICAN HOMŒOPATHIC
JOURNAL OF OBSTETRICS

AND

GYNÆCOLOGY.

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THE AMERICAN HOMŒOPATHIC JOURNAL
—OF—
OBSTETRICS AND GYNÆCOLOGY.

VOL. I.

ANN ARBOR, MICH., JANUARY, 1885.

No. 1.

INTRODUCTORY.

This journal is respectfully dedicated to the so-called "general practitioner." The only apology we have to offer for forcing upon the profession this additional department of *THE ADVANCE* is its necessity. While the busy practitioner does not hesitate to subscribe for a medical journal containing general reading matter, he often passes by any special work published by, and in the interest of, a special class of practitioners.

The necessity of placing gynæcological information before the general practitioner may not be apparent to the expert, whose opportunities have familiarized him with the essential details of his special practice, but from the gross errors we have seen committed by those who are deficient in experience and teaching, from necessity, this journal will, we think, prove valuable to them in every day life. The text books on *Diseases of Women* occupy an entirely different field in medical literature from a journal. They do not permit of the details of clinical cases and practical hints which are so important to the physician.

While we regard, to some extent, gynæcology as a special practice, we do not forget the disastrous effect this has had upon the general practitioner, who thinks he must not examine, treat or operate upon one of his lady patients, if she complains of any uterine or ovarian symptoms, when a spe-

cialist resides in his respective locality. It is, however, perfectly proper for a physician to make a reputation for special work in any one department, but this can best be accomplished by and through his general knowledge. We think too many mush-room specialists and specialties have sprung into existence of late years, to the detriment of the general practitioner.

In speaking as we do, let it be understood we do not allude to ophthalmology or to otology, or to exceptional and grave operations, where both experience and special preparation are necessary in order to justify a man in undertaking them. We should share our responsibility with another in consultation, but how much more satisfied are we if we can obtain the assistance of one who has had a ripe and cultured experience, founded upon a wide and general medical knowledge, than the narrow views of a specialist whose opinions are based upon a limited range of observations and practice.

We shall endeavor to meet the wants of the general practitioner, and interest the specialist, and at the same time we shall give particular attention to pathological and clinical questions in their relations to uterine and ovarian diseases, and present such papers and abstracts of discussions as will be of special advantage to our subscribers. Each and every complexion of "potency" will receive, at our hands, respectful attention and consideration. To borrow an expression from the *Clinique*, "if we take care of the journal, the *cause* will take of itself."

NEPHRECTOMY.

SUCCESSFUL REMOVAL OF A KIDNEY.

BY PHIL PORTER, M. D., Detroit.

The gratifying success which I have met in abdominal surgery during the last five years prompted me, from time to time, to venture into fields hitherto avoided, to a more or less extent, by operators, and following the reports

of my last hepatotomy and laparotomies, I again publish another successful nephrectomy in a young woman, twenty-two years of age.

The history of the case is interesting on account of the differentiation it enables one to make. During the last six months the patient had several attacks of hæmaturia which prostrated her very much. The gastric disturbances became distressing, and general emaciation marked. I was called to examine the case by her attending physician, Dr. F. X. Spranger, who had discovered the tumor in the right side of the abdomen, filling up the space below the liver, down to, and in the right side of the pelvis. Drawing out the history still further, I ascertained that the patient had a voracious appetite, but the food did not seem to satisfy. The tumor had evidently grown rapidly—which was a suspicious symptom—as the patient had not noticed any increase in her size until the last two months.

She did not complain of any sharp or lancinating pain, but of a dull, heavy ache in the lumbar region. The attacks of hæmaturia were not associated with pain. The urine presented a faint smoky hue, and at times a reddish brown color, with small clots. The patient was anæmic, and she complained of suffocation every evening, that was distressing. Night sweats were persistent, and the temperature $99\frac{1}{2}^{\circ}$, pulse 130. She had, in many respects, the characteristic symptoms of phthisis. The shape of the tumor and its locality enabled me to differentiate between an enlarged kidney and the spleen, and yet I could not account for a *dull, tympanitic* sound found on percussion over the tumor, which, however, later on, proved to be the colon passing over and adherent to the tumor. Several nodosities were detected on the growth in different places. The development, density and other characteristics, precluded the idea of an ovarian tumor. It was oblong in shape, measuring about eight inches in length and four to six in diameter. Movement of the tumor was limited and requiring considerable force. Manipulation caused no pain. Examination of the urine

showed pus in considerable quantity, with disintegrated blood corpuscles. Examination per vagina was negative. Soon after the examination the patient had another severe attack of hæmaturia, and her life was despaired of, but under the faithful attention of Dr. Spranger she soon regained sufficient strength to justify an operation.

The day set for the operation found our patient with a pulse of 120 and temperature of 100°, but twelve hours after the removal of the tumor her pulse had dropped to 120 and temperature to 99°.

The median line was selected for the incision, as I anticipated some difficulty in breaking up adhesions and an opening at this point enables the operator to work at a greater advantage. Nor was I disappointed, for the tumor was adherent to all of the surrounding structure. Commencing over the center of the tumor, I gradually and carefully worked my way down to the left side and then to the right, until I finally released the body of the growth from its bed. Raising it from the cavity of the abdomen with my giant fibroid volsella, I placed the handles in the care of Dr. Walsh, who was assisting me, and with a scalpel I made a complete circle of the tumor, cutting through the capsule only, which was very vascular. I then stripped down the capsule, working toward the pelvis of the kidney all the time, at which point I desired to make a pedicle for the purpose of either ligating or treating with cautery. After reaching the base of the kidney I clamped all vascular approaches and severed the organ from the capsule and attachments, and removed it from the abdomen. The pedicle was then treated as is my usual method for ovarian cysts. Thoroughly cleaning the abdominal cavity, the incision was closed with silk worm gut sutures, and the wound dressed in the usual manner for laparotomies.

The spleen was found enlarged to twice its natural size. Aside from a decided anæmic appearance of the intestines and a small undeveloped uterus, the abdominal organs were apparently healthy.

The patient was under an anæsthetic one hour and ten minutes. Absolute cleanliness was carried out in every department of the operation.

The patient's recovery was rapid and continuous, as well as gratifying to the operator. All of her former unfavorable symptoms disappeared with the removal of the kidney.

Some time after the operation I made a partial examination, which will be extended when time permits, of the kidney and found, on opening the organ, pus in small cavities, chiefly in the upper portion of the kidney. Portions of the organ were undergoing fatty degeneration. The cancer had not invaded the pelvis of the kidney or ureter.

Since the operation the patient has gained fifteen pounds in weight.

UTERINE SOUND: ITS USE AND ABUSE.

BY HEYWARD SMITH,

Consulting Physician to the London Woman's Hospital.

Reported by our special correspondent, H. H. CRIPPEN, M. D., London, England.

The sound, as a gynæcological instrument, is not less useful than the speculum, although its use is attended by more danger. Its development into the form now in use is the result of gradual modification of an early instrument resembling the lithotrite. One great error in these early forms is that of having the notches for measurements of the uterine cavity on the interior curve of the instrument. Improvements followed in making the sound of malleable metal, in placing the markings for uterine measurements on the exterior curve, and in changing the gradual curve by making a distinction of the uterine from the vaginal portion, in placing the former at an angle to the latter parts; this angle being at a distance from the uterine end corresponding to the measurement of the normal uterine cavity. To this has been added an improvement by Dr. Protheroe Smith in the shape of a handle parallel to the uterine course. The

use of this is apparent in the fact that by noting the direction of the handle, the position of the uterine cavity relative to the pelvis may be accurately ascertained.

In speaking of retroflexions we must allow that the sound is of great value, both therapeutic and diagnostic. The replacement should not be accomplished by the sound alone but should be aided by the finger behind the cervix. As the uterus assumes a normal position, the finger should be brought on to the anterior surface of the cervix to steady it in that position. This manœuvre must be conducted slowly and gradually, care being taken not to cause the uterus to rotate through a semicone. To avoid this, the leverage must not fail upon the handle of the sound, but upon the center. This use of the sound in reposition has been somewhat changed, by adding a joint at the angle of union of the vaginal to the uterine portion for the purpose of moving the latter portion by means of a screw and ratchet. The best form of this repositor is that in which the ratchet and screw can be disengaged so that the instrument may be used as an ordinary sound. It must be borne in mind that uteri in the condition of retroflexion are subject to hyperæmia, congestion, and in many cases, inflammation. These conditions must be corrected before attempting a reposition.

As an instrument of differential diagnosis the sound is invaluable. In various tumors of the pelvic organs, the extent to which they encroach upon the uterine cavity, their adhesions or non-adhesions to the uterus as well as their relations to it may be ascertained. Further than this, in diagnosis, the sound becomes, as it were, a prolongation of the finger, being used as an organ of touch, especially in ascertaining the condition of the uterine cavity. In using the sound with regard to differential diagnosis, information is sought as to the length and character of the uterine cavity, the position, mobility and relations of a neoplasm, and the ease with which the instrument penetrates the canal of the uterus. In diagnosis of adhesions of a tumor to the uterus, pass the sound into the uterus, then by moving the tumor, if

attachments exist, the handle of the instrument will move in accordance as the uterine extremity is carried to and fro by the tumor's dragging upon the womb.

In the introduction of the sound different modes have been advocated by various writers. My usual method is to stand behind and over the patient as she lies on her left side, pass the right hand and introduce the sound with the left hand, using the finger of the right as a guide. The especial advantage of this mode lies in the fact that in standing behind and over the patient one can picture in the mind the relations of the direction taken by the sound.

Special modifications of the sound have been made, giving applicability to its various uses, both therapeutically and diagnostic. But some of these become a positive disadvantage in depriving it of its delicacy. Mechanical intervention between the part to be examined and the touch becomes a disadvantage which increases as our instruments become more complicated. Our most useful therapeutic modification is probably that for dilatation; a dilator should have a straight uterine portion, the disadvantage of the curve being in the fact that in the introduction of medical applications, cauterics, etc., after dilatation, they are best effective if carried into the uterus in a straight line. A last addition to uterine dilators is that of *McNaughton Jones*, consisting of a small bulbous portion, then a contracted part and finally of a larger bulb. One drawback in the use of this dilatator is that it produces too much unnecessary action in the cervix; first a dilatation, then a contraction and a final dilatation. The dilator as used in Soho Square Hospital consists of a straight uterine portion of two and one-half inches, placed at an angle with the vaginal portion, the point being slightly conical. This form of dilator has given us great satisfaction; by the use of a graduated series we can produce a sufficient dilatation for therapeutic purposes in about one minute, in uteri that have borne children.

In *resumé* we may safely say that the sound is one of the most useful gynecological instruments for differential diag-

nosis, for flexions and versions, for touch and diagnosis of the uterine canal. It should be handled carefully, not used (as an early writer claims, in horror) as a "uterine poker," but with as light a hand and as careful a touch as a male catheter.

HINTS TO SPECIALISTS.

J. T. KENT, A. M., M. D., St. Louis, Mo.

A quasi-homœopathic gynæcologist once said to some of our students: "If you undertake to cure these diseases (displacements) with your homœopathic remedies you will fail. I have tried remedies and have never found them of any value, I now replace the uterus and adjust a pessary immediately." In such cases what has become of the law? And yet some specialists cry out that the specialties are not sustained. Shall the common average physician sit down and worship such gynæcology, when he, though not pretending great skill, can do better than the specialist, taking his word for it. This is not to underate him who uses all his means in the right place for the greatest good. There is room for all the specialties but our specialists must do better than the common practitioner or they must not complain of being scolded. We expect that the specialist shall not simply and only know the mechanical portion of his department, but that he shall also be expert in the *Materia Medica* of his department. It will do for the average doctor to say, "oh! you *Materia Medica* fellows are experts; we are too busy to learn these fine things;" but it will not do for our specialists to be guilty of ignorance in this department. They must know how to cure with remedies or they must not lay claim to special qualification. When I talk with a specialist I expect to learn of special indications for remedies, and I am generally disappointed. The specialist has the same pathogenesis to work out his cases by that all have, but he generally relies on somebody's hard work try-

ing to make them fit his cases, and as a rule it does not apply. Every man who claims special excellence in any one department should search the provings for a therapeutics peculiar to his own demands, and build for himself. Several years of hard study will reward his labors, and he will know none the less of the accumulated experience of others in the application of these same pathogeneses recorded in works on therapeutics. The specialists stand accused of ignorance of the *Materia Medica*, indeed they are their own accusers when they acknowledge the demand made upon mechanics for the majority of cases treated. Failure to cure by the *Materia Medica* should be the exception in all non-surgical diseases, and when other means are resorted to they should be looked upon as but palliative and not curative. There are instances when it is judicious to palliate, but let no man call these means curative. The curse of homœopathy is the too free use of palliatives, and this is because of the wide spread ignorance of the philosophy of homœopathy and the *Materia Medica*. Doctors use palliatives when they do not know what else to do, as the surgeon cuts off the leg when it is the last resort. Had he known how to prevent the disease processes he would have saved the leg. It is a common practice to apply a support to hold in position a displaced, uterus and then begin to build up by medicine. Who is wise enough to know what remedy to administer after the symptoms, the only true expression of the disease have been removed? This is the way some of our specialists go about it, "bass-ackwards," and then complain that "the law is a failure." There might be some reason in first taking the symptoms by which to select a remedy, and then applying a pessary; but to the experienced the folly of this will appear as it is so well known that the symptoms immediately disappear without mechanics. Support is not needed after the right remedy has been taken two days. Again if a support has been used one has no evidence of good or bad selection.

The cure of these diseases are possible without support with pure medicinal treatment, the demonstrations are too numerous to deny; then let the specialist lay no claim to proficiency who is not able to do better than the average doctor. It matters not how often a woman is examined, only so she is safely, gently and permanently cured. The question of frequent examinations is one to be laughed at; but the question arises, first of all, do you cure safely, quickly and permanently. If the physician can make more out of a patient by making frequent observations, and his patient will stand that kind of business, it is well enough and he must settle the matter with his own conscience if he have such a thing; but he must not interfere to delay recovery which should be more or less rapid in most cases. I have the right to take exception, and to criticise, when women go to specialists and pay enormous sums for treatment of diseases that should be cured with a few doses of a properly selected homœopathic remedy. These things have occurred, and not with our tyros but those standing in the lead. I can produce the notes if any man dare dispute it, and the worst part of the whole business is that the greatest pretensions are cloaks to the most profound ignorance. These men are generally too wise (?) to be taught by an American author or teacher. They go on with their circumscribed armamentarium for local use, and the thimbleful of *Materia Medica* which is all they have serves the purpose of homœopathic show. If the representatives of the homœopathic school would learn the polychrests so that they could compare them throughout, the demand for mechanics and local slops would decrease. There should be no fashion in medicine; what was good fifty years ago in the hands of the masters should be just as good to-day, and the deviation comes out of departing from the methods of the early physician who had not the labor-saving and brain saving machines. If the masters could cure such cases with simply great labor, how much better ought we to do? The high

degree of perfection will never come to our specialties so long as the specialists are content with the palliatives now in vogue. I am only astonished at the amount of palliation that can come from some of these mechanical supports. But I am never astonished at any great skill in the use of remedies in the hands of our specialists, and I still fail to see any good reason for sending a non-surgical case to a specialist to be treated. When they arrange a family circle of their own to evolve the *Materia Medica* and a correct philosophy, then and not until then can they claim patronage that naturally should fall to the specialist. I fail to see any good reason why a homœopathician should advise a patient to consult a professed homœopathic specialist, whose principal means are those developed and used by the allopathist. If there is any reason to suppose a homœopathic physician can use allopathic tools to a better advantage than the allopathist himself, I fail to see it. If allopathic means are better than ours, why uphold the law which is the *sine qua non* of homœopathy? If a combination of allopathic and homœopathic means goes better why not associate with congenial spirits, the eclectics. [Give us more like this.—ED.]

OVARIAN TUMORS.

BY HENRY N. GUERNSEY, M. D., Philadelphia.

[From a monograph.]

Very much has been written on the subject of ovarian tumors. Nearly all writers, with scarcely an exception, describe at length their varieties, consistency, appearance, position, etc., as though they were a something separate from the living organism and vital principle which animates them, as something hidden internally and material, however subtle their nature may be supposed. The symptoms that accompany each variety are delineated with the accuracy of a portrait painter, and drawn as though they were stereotyped.

On the contrary, no two cases have ever been known to exist where the symptoms were identical, nor is it possible that any two cases will ever be found to present more than a similarity. The truth of the matter may be stated as follows:

All ovarian tumors are of dynamic origin. So long as health reigns supreme there can be no diseased condition. Disease only exists on a departure, however slight, from the normal state of the vital force, which causes the patient to feel slightly indisposed. This condition of affairs may continue for months or years, and no ovarian tumor yet appear, not the slightest vestige of one. At length this increasing morbid influence exhibits a slight derangement in either of the ovaries, and by degrees the development of an ovarian tumor makes its appearance. At first so small as to be only recognised by a powerful microscope, later the naked eye can detect the result of the morbid influence, and the then small tumor, still augmenting, may gain in the aggregate the weight of one hundred pounds. In fact the size and weight are only limited by the endurance of the sufferer.

This is the real pathology of all tumors and other diseased conditions. It is the *living* pathology *only* that concerns the physician as a healer. The material is *per se* of no account beyond its symptomatic value. If it is true, and *true it certainly is*, that an abnormal state of the vital force has been the contributor to all this growth, why, if the doctrine of Homœopathy be true, should we not be able to remove anomalous force and to establish in lieu thereof a health-producing dynamic power? Why do we not take heed to Samuel Hahnemann in the treatment of the sick?

Dr. John Hunter, one of the *astræ lumina* in the galaxy of surgeons, even in his day held the operative part of surgery in the lowest estimation. "To perform an operation," said he, "is to mutilate a patient whom we are unable to cure; it should, therefore, be considered as an acknowledgement of the imperfection of our art." He avowed himself outmastered, completely conquered, by the progress of the disease in question. He felt humiliated when obliged to resort to

the knife in cases that he felt ought to be cured by medication only.

Many and many a time have I heard the venerable Valentine Mott deplore the necessity of a surgical operation. He would raise a pitying eye to his numerous class of students and say: "Gentlemen, we are again mastered, repulsed, by the unsubdued progress of this disease. Again we are compelled to resort to the *opprobrium medicorum*. The art of surgery is nothing more. I am sorry, very sorry, that this person could not have been cured and thus saved the necessity of this degradation to the healing art."

If our allopathic brethren take a stand of this kind should we not expect more of Homœopathy? Yet the truth really is, that most of our homœopathic surgeons resort to the knife as the very first remedy, declaring it to be the only remedy, and that it should be resorted to at once. Gentlemen, this is a *mistake*, and shows great mental weakness and want of knowledge of the fundamental principles of our art. It shows a disposition to succumb to the inroads of diseased conditions, to retreat from the enemy, and to sink into mere routine.

It may be said that I do not encourage the art of surgery. Nothing can be further from the truth. I encourage it in the proper way. Which of the two is the more noble—the art of *healing*, or the art of *relieving* by marring the human system? Cutting is simply palliative; it does not cure. The scalpel can never, no, never, remove from the system that dynamic force which brings to view the product of disease. The surgical art should be held in abeyance, faithfully and religiously, as a *dernier resort*. I am well aware, and so is the surgeon, that a bold and skillful operation, successfully performed, carries with it the *eclat* of admiration and applause of the populace, but to every thoughtful mind, how much more admired and lauded is a thorough cure of the same malady by medicine, the only legitimate and satisfactory mode.

That ovarian tumors are curable by medicines we have

sufficient proof from records made by physicians occupying the highest rank in the profession.

When we use our *Materia Medica* in complete accordance with the rules so ably advanced and expounded in Hahnemann's *Organon* and his *Chronic Diseases*, we obtain the most brilliant success in treating this formidable complaint. Let us cite a few examples of undoubted authority, showing that ovarian tumors are curable:

In *Raue's Annual Record* of Homœopathic literature, 1870, p. 70, we find the first case on record, so far as I know, and it was a cure effected by myself nearly twenty years ago. The case came into my hands after it was pronounced by several of our best allopathic physicians and surgeons to be a well developed instance of ovarian dropsy which nothing but the knife could relieve. The fear of so formidable an operation induced her to seek my aid. The tumor was so large as to fill the entire abdominal cavity, rendering stooping impossible. There was also an anasarca condition of the cellular tissues throughout the whole body. The characteristic symptoms indicating the remedy were *pains like bee stings* in the ovarian cyst, very scanty urine and *no thirst*. By administering *Apis mel.* in strict conformity with our Law of Cure, in the course of ten months she was restored to perfect health. A few months after the cure she was found to be pregnant, and in due time gave birth to a healthy child. This woman and her husband and child are still living in this city, and can be seen by any person desiring to do so by calling on me for their address.

In the same *Annual Record*, p. 244, we find another case by T. Black, M. D. This, an ovarian cystic tumor, was cured in six months' time by Bromide of Potassium. Symptoms not recorded. He also reports another case cured by an allopathic physician and by the same remedy in the same course of time.

Another case found on same page, was nearly cured with *Rhododendron*, but the patient, from some unknown cause, discontinued treatment.

On page 245, same record, our lamented friend, C. Dunham, M. D., records a case. This was of some years' standing, and pronounced by several of undoubted authority to be an ovarian tumor and incurable. It was firm and elastic and very painful; the patient could not stand erect nor walk; when the paroxysms of pain came on the only mode of partial relief was by bending forward almost double. From these symptoms Dr. Dunham prescribed *Colocythis*^{2c}, to be taken at every paroxysm of pain, and repeated every hour till relieved. The paroxysms gradually diminished in frequency and severity till she had recovered sufficiently to walk a long distance. She went to Europe, carrying with her a vial of *Coloc.*^{2c}, which she continued to take as occasion required. After five years she reported herself to Dr. Dunham, in New York, when no trace of the tumor could be found. No doubt about Dunham's diagnosis.

In the same *Record*, 1871, p. 145, a case is reported by Dr. Payr. The left ovary was affected. *Bryonia* was first prescribed, then *Apis* finished the cure. No symptoms given.

Another case is recorded on same page, by Dr. Bojanus. The remedy first administered was *Bellad.*, then *Bellad.* and *Natrum sulp.*, in alternation; finally, *Kali carb.* completed the cure.

Dr. Chauvet, of Paris, reports a case on same page, of an ovarian cyst, in a woman of the laboring class, æt. 22, cured by *Rhus*.

A remarkable case is reported on the same page, by William Gallupe, M. D., Bangor, Maine, that he cured with *Podoph. pelt.*^{2c}. The tumor appeared first on the left side, and was as large as a ten quart pan, filling pretty nearly the entire abdominal cavity. After this had disappeared, some years later, another tumor was developed on the right side. This was also completely cured by the use of *Podoph. pelt.*^{2c}.

The next case is by Dr. Richard Hughes, of London, found in the *British Journal of Homœopathy*, 1872, p. 793. He states it to be an *undoubted* case of ovarian dropsy, and it was cured by *Kali bromidum*. Afterwards the abdomen

seemed filled with fluid, but it was entirely removed by *Apocynum*, *Arsenicum*, and *Apis*.

In *Raué's Annual Record*, 1872, p. 173, a case is recorded by Dr. P. H. Hale. An ovarian tumor as large as the head of a new-born child was cured in several weeks by an infusion of ten or twelve bees, a tablespoonful every four hours.

On page 147, *Raué's Annual Record*, 1873, a case is reported by Charles Sumner, M. D., of New York. His case was so diagnosed by an allopathic physician, and it was also his honest conviction. It was the size of a quart bowl. He continued the use of *Calcareo c.*^{6m} for fifteen months, when there was not a trace of the tumor remaining.

Professor A. E. Small has reported two cases on p. 173, of the same *Record*. One was very much benefitted by *Apis*, the other satisfactorily treated by *Carbo an.*

In *North American Journal of Homœopathy*, Vol. XXI, p. 553, is a case reported by my friend, A. M. Piersons, M. D., of New York. The tumor was seven inches in length, five inches in breadth, and three inches thick, as nearly as he could estimate. Cured by *Apis*^{40m}.

A cure by Dr. Gilchrist is recorded on the same page. *Coloc.*^{1m} was first administered; a month later, *Coloc.*^{cm}, and in a few months the patient was perfectly well.

Dr. Dudgeon, England, reports a case of ovarian tumor cured by *Graphites*^{12m}, in *British Journal of Homœopathy*, 1873, p. 187.

Mercy B. Jackson, of Boston, reports a case in the *North American Journal of Homœopathy*, Vol. XXII, p. 93, in which the general health improved under *Silicea*, and the tumor diminished under *Platinum*.

A case reported by Dr. Praul, on the same page was very much benefitted, if not entirely cured, by *Kreosote*.

Nearly two years ago a lady came to me from the far West, with an ovarian tumor of immense size. The abdomen was so distended that stooping was impossible. She was pronounced by some of the best surgeons and physicians in the West to have ovarian dropsy, and that nothing but

the knife would be of service. She came to Philadelphia with the hope of finding better encouragement from our best medical men here, but all pronounced the same verdict as those in the West, until she consulted me. Finding considerable encouragement from my view of the case, she placed herself under my care. She had not much pain but was restless at night; was worse after midnight; very weak; a little exertion fatigued her greatly. All her symptoms indicated *Arsenicum*, which I gave her in the 40^m potency. Improvement was soon manifest, and in this manner: she slept better, was not so restless at night, and felt a little stronger. General improvement continued for several weeks, when she became satisfied that her size was diminishing. This good effect continued for ten months, when she returned home apparently quite well. Until this summer she has enjoyed good health, but a few weeks since (Aug. 15, 1878) she wrote me that her size is again increasing, and she fears a return of the tumor. She is again under treatment with every hope of perfect success. Was eventually cured.

Aug. 15th, 1878. I have just discharged a cured case of ovarian dropsy that I commenced treating on July 28, 1877. The tumor was on the left side, as large as a two quart measure, producing a constant ache and sensation as if a ball were lying there. She slept with her arms stretched over her head; is of a leucophlegmatic temperament; menses profuse and too often; her feet felt as if cold, *damp* stockings were on them. *Calcarea c.*^{85m} did her great service for several months. Finally her symptoms changed completely; *Sepia*^{55m} was given and has made the cure complete.

Another marked case comes to my mind which I cured several years ago. The tumor was as large as the head of a new-born child at full term, situated in the right ovarian region, and was caused by falling over a wash-tub. There was pain at every menstrual period, terribly forcing and bearing down, as though everything would issue at the vulva. This case was cured perfectly and completely after six months, by *Belladonna*, given at every menstrual period.

[The pages of this journal will be open to any one who desires to discuss this much vexed question of ovarian therapeutics. It is a subject of such a diversity of opinion that we would be only too well pleased to have the matter thoroughly brought out. Dr. Guernsey, in his paper, has made use of the same old time-honored and often-quoted authorities and remedies for his proof and now let us have something fresh for this truly interesting field of surgery. We regard the *diagnosis* as the prime factor in the disagreement. We have seen a hypertrophied kidney diagnosed, by four allopaths, as an ovarian tumor. T. Spencer Wells says: "Gentlemen, a *positive* diagnosis of an abdominal tumor can be made after an exploratory incision.—Ed.]

A CLINICAL CASE.

BY G. M. PEASE, M. D.

Prof. of Gynecology and Surgical Diseases of Women; Hahnemann Medical College of San Francisco, Cal.

UTERINE FIBROIDS.—It is not intended to enter into the pathology, etiology or therapeutics of uterine fibroids, but only to relate a case which may serve to interest some one. The first portion of this article is given as written by J. S. Leffingwell, M. D., of Oakland, Cal., and followed by the relation of the results of examination in consultation and subsequent autopsy.

"May 31st, 1884, was called to see Mrs. H—, æt. 41, inclined to corpulency; complexion fair; the mother of several children. I found my patient seated in her easy chair, cheerful and without any appearance of ill health, except a peculiar unnatural transparency of the skin. She gave a history of her case as follows: In the spring of 1876 she was delivered of a still-born child, which was followed by an attack of puerperal fever, pelvic abscess and rectal fistula. For the latter she underwent an operation with the knife. For three or four months after this her health was

comparatively good. Pains then commenced in the pelvic region and back, also in the right ovary extending to the groin; was also subject to severe attacks of uterine hæmorrhage, leaving her weak and prostrated, but with less suffering. Her present symptoms were, pain in her back, with a bearing down sensation like labor pains, also pain in and over the eyes. Apis. Bell. and Puls were suggested to my mind, by these symptoms, as appropriate remedies, and I expressed no doubt as to my ability to give her relief. (Subsequent events proved that I was decidedly mistaken in my prognosis.) My patient then said that her last physician had come to the conclusion that she must be pregnant. This remark caused me to decide on making a more thorough examination; and having placed her in the proper position I endeavored to find the placental souffle, but it was not there. Then by percussion and palpation I found a large abdominal tumor extending from the right to the left iliac region, and upward to the umbilicus. Digital examination per vaginum showed that the cervix was not shortened, but patulous, and the os somewhat dilated. I then said, you need not have any fear of pregnancy, such is not your condition. Then came the question, "What is it?" From the history it evidently was not an ovarian cyst, and there was the hæmorrhage. Under these circumstances, with all the symptoms pointing to a fibroid growth of the uterus, I so diagnosed the case. My patient immediately said, "I have known it for the last five years, but my physicians have all denied that I had anything of the kind." Having a due regard for the opinions of my predecessors, and my patient receiving only temporary relief, after two or three weeks treatment, I decided to consult with Prof. G. M. Pease, of San Francisco, with reference to my diagnosis, and also in regard to an operation for her relief. This consultation was held without further delay, and leaving further report for Dr. Pease, I will merely state that the patient lived until the 18th of August, when death put an end to her sufferings.

During her illness she often expressed herself as receiv-

ing great relief from the following remedies, which were administered as indicated: Apis, Belladonna, Pulsatilla, Chamomilla, Calcarea c., Conium, Lachesis Carbo veg. and Baptisia."

June 24th, 1884, I was called to see Mrs. H—— whose case he has described above. She was in a very nervous state, and dreading the examination which she felt must necessarily be made; was sure it would be impossible for her to bear the pain, particularly if a uterine sound were to be introduced. One or more of her physicians prior to Dr. Leffingwell had used a sound and occasioned intense suffering, consequently she had demanded, and prepared for, the employment of chloroform. Promising to comply with her wishes if I was to do anything which would give her pain, she consented to allow me to begin my examination without any anæsthetic. Placing her in the dorsal position I made a digital and bi-manual examination, which revealed an enlarged uterus; cervix lacerated about half its length and considerably hypertrophied; the body of the uterus directed backward and towards the right side, while from the fundus above was a large mass which appeared to be strongly adherent at some point near the lower portion of the liver, the exact point being difficult to determine, owing to the extremely thick adipose tissue covering the abdomen. This extra uterine growth seemed to take its origin about one-third to one-half the distance down upon the body of the uterus, while upon the left at the lower point of the larger growth, there was plainly felt another mass projecting from the left side of the body and coming down fully to the vaginal junction of the cervix, while below this the whole pelvic cellular tissues were congested and adherent to the tumor above, thus making a firm anchorage upon the side. There was, however, a very slight apparent mobility of the uterus upon the right side, when pressure was applied upwards, but upon this point I was uncertain. As up to this time the patient had expressed no desire for chloroform, I quietly took a full sized sound and introduced it as far as

the internal os, when it was found to be too large to pass without pressure, and a smaller one was substituted and introduced to a depth of three and three-quarter inches. Manipulation with the probe gave the probable presence of a sub-mucous growth in the left lateral wall of the uterine cavity near the fundus, which judged to be about one inch in diameter. The probe was then laid aside, and a small gum catheter employed for the purpose of ascertaining the possibility of a greater depth of the cavity. When the sounding, which was followed by but little hæmorrhage, was completed, I announced to the patient that the examination was concluded. She expressed great surprise because there had been no pain as she had expected. My diagnosis was in conformity to the facts related, a large extra uterine fibroid, or one large and one smaller one connected at their bases, and extensive cellutic deposits, most of which was of long standing. In addition I noted the existence of an intra-uterine, sub-mucous, fibroid, possibly of the size of a pullet's egg.

The attending physician having heretofore been choosing remedies which he found indicated from time to time, I offered no special suggestion in that direction, but advised cotton tampons and glycerine, with hot vaginal baths for the purpose of reducing the inflammation and softening adhesions.

The advisability of an operation being discussed, my opinion was given strongly against it, certainly while the cellutic deposits remained as they were. A month later, July 24th, I made another examination, which revealed practically no change.

Several interviews had with the husband and Dr. L., during which great pressure was brought to bear upon me to operate, resulted in another examination with the hope that I might have made an error in diagnosis, and would in consequence perform the desired operation. Following this third examination I consented to make at least an exploratory incision, and if feasible to continue, but first stipulating

for some days delay. The patient did not, however, live the full number of days arranged for the probation, and I was allowed to make an autopsy about twelve hours after death, with the following result: Cutting through a very thick adipose tissue the peritoneum was opened and revealed a mass which it is difficult to describe. A large tumor was lying in the right side of the pelvis, extending upwards and adherent to the lower point of the liver. An attempt at lifting it resulted in tearing the already disintegrated capsule, and when a mass of the tumor was grasped in the hand it would escape between the fingers as if it had been dough. The capsule was found to have been ruptured before death, and to have allowed the escape of considerable pus into the abdominal cavity. The lower portion of the tumor was a trifle more firm in its character, though pretty thoroughly broken down, and the two combined, or one of irregular shape, agreed in form and size very closely with the opinion given at the first examination. The ovary upon the left side was found embedded in a mass of celluitic deposits, and was strongly coherent and enlarged in size, while that of the right side partook much of the softened character of the tumor in its immediate vicinity.

After tearing away the uterus and its adherent masses loose from the attachments, it was removed by cutting through the vaginal walls. Being opened through its long axis a sub-mucous fibroid was discovered at the identical point which had previously been diagnosed, and its size corresponded very closely to that of a pullet's egg.

The post-mortem examination was thus a perfect endorsement of the diagnosis and prognosis, and was a source of sorrowful comfort to the bereaved husband who was thereby convinced that an operation undertaken at any time after the discovery of the real condition, must have resulted fatally.

BY W. J. H. EMORY, M. D., GUELPH, ONT.

LACERATED CERVIX.—Mrs. L., æt. 30 yrs. Saw her first on August 6th, 1883. She complained of constant desire to urinate, accompanied by great vesical tenesmus; urine

passed drop by drop, very highly colored and passed with great pain. Prescribed Canth. which gave temporary relief, afterward prescribed different remedies with a similar result, and on closer examination ascertained the following: Four years ago had her first and only child, a boy with unusually large head. Labor pains came on very rapidly and with such violence that the child was born in a few minutes, and before a doctor could be called. For several days suffered from almost constant hæmorrhage; made a very slow recovery and has never been well since. Suffers from both menorrhagia, and metrorrhagia and constant heavy excoriating and profuse leucorrhœa; coition is always painful and followed by a show. These symptoms induced me to seek an examination, which revealed as follows: Vaginal walls exceedingly flabby and relaxed; rugæ enlarged and sensitive pressure on bladder between the finger in the vagina and hand over pubes revealed exquisite tenderness and caused great pain; neck of womb enlarged looking towards vulva; around the os very sensitive; os flabby and gaping open allowing the finger to pass in three-quarters of an inch, could then be carried out to either side without withdrawing. Carrying the finger along behind the posterior surface of neck of womb it came in contact with a hard, cylindrical body which proved to be the body of the uterus flexed at an acute angle; but lest I should mistake an intermuscular fibroid for the body of the uterus, a digital examination was made per rectum which revealed the fundus pressing down upon the internal sphincter. A visual examination through a bi-valve speculum verified the foregoing and showed the cervix to be much enlarged; the os which was really not the external os but the remnant of the cervical canal plugged up with viscid white mucous which could be stretched out to almost any length, and surrounded by an area (with a radius of nearly half an inch) of blood red erosion which entirely disappeared on drawing the lips of the cervix together. I immediately advised an operation which, after consultation, was granted. The woman was kept quiet in

bed and after a preliminary treatment of two weeks during which time the vesical irritation and sensitiveness were entirely removed by carefully selected remedies.

On August 27th, five days after the cessation of the menses, assisted by Drs. Emory, of Galt, and Cowan, of Guelph, the operation was performed as follows: The woman was placed in the lithotomy position on a suitable table and brought thoroughly under the influence of an anæsthetic. By means of two Sims' duck bill specula, one above and one below, held by assistant, the neck of the womb was fully exposed and, grasped by a double tenaculum, was drawn nearly to the vulvular orifice without difficulty. Then a needle (of which either Emmet's or Sim's is excellent, Emmet's being used in this case) threaded both ways with fine strong silk so as to leave a loop, was grasped in a strong needle forceps and made to transfix the center of the cervix passing through the upper part of the cervical canal; then, after placing a long piece of stout silk cord in the loop, it was drawn through, the cord of course following. A loop of the cord was then drawn out through the cervical canal, and after cutting it in the centre, the ends were tied together leaving a loop of stout cord through both lips of the cervix, by which it could be steadied and controlled, and for which the tenaculum was now altogether abandoned. Now taking one of these loops in each hand, the lips of the cervix are first separated so as to ascertain the position of the cervical canal, and then drawn together so as to determine the site and size of the future os externum. Now having mapped out the extent of surface needing to be denuded, the cervix being steadied by means of the loops of cord which are now handed to an assistant, the work of denuding the edges of the fissure and dissecting away all the cicatricial tissue is at once proceeded with, a long pair of curved scissors being used principally for this purpose. This being thoroughly accomplished on both sides, the next thing in order is the introduction of the sutures, which is by all odds the most difficult part of the operation. The ordinary surgeons' needle

is not strong enough to pierce the dense gristly tissue; the best are those short, round, lance-pointed ones devised by Dr. Sims or those of Emmet. Several needles should always be on hand as they are liable to be broken. The needle threaded as before and grasped in a strong holder is passed deeply through both posterior and anterior lip of the cervix beyond the angle of the fissure, then the suture proper (which in this case was strong catgut) is passed through the loop of silk in the needle and made to follow it through the lips of the cervix. In like manner all the stitches are inserted, four in number, before tying any of them. The wound is syringed several minutes with a solution of Calendula in hot water to cleanse the part and check the hæmorrhage which has been profuse during the whole operation and troublesome on account of obscuring the parts. The sutures are now tied, which so closely coaptate the surfaces as to effectually arrest all bleeding. Then after thoroughly cleansing all the parts the sound is introduced, the uterus restored to normal position, and the woman placed comfortably in bed.

The pain after the operation was so insignificant that it was never complained of. The after-treatment consisted in securing as absolute rest as possible for a few days. The urine was drawn at intervals for forty-eight hours, after which time she was allowed to go on hands and knees and relieve herself. This position is preferable to the bed pan, as in the latter position the urine might find its way to the healing surfaces and interfere with that process. The bowels were kept bound for four days by opium suppositories when they moved naturally. At the end of eight days an examination showed the wound to be healing kindly; but there was not a vestige of the catgut sutures to be found they having been absorbed.

At the end of two weeks the patient was up and reported herself as feeling well, and, inside of three weeks was walking all around the city without either pessary or support of any kind. An examination showed the wound entirely

healed and the womb in normal position. Inside of four weeks she had been around on foot calling on her friends like one with a new lease of life and telling them she had neither ache nor pain, and had not been so well for five years, and is at present going about her household duties a well and grateful woman.

Mrs. B., a married lady, aged 34. Thirteen months ago sustained a bi-lateral laceration of cervix-uteri. Since which time has not known what it is to be well. After confinement made a very slow recovery, suffered from prolonged lochial discharge, local pains, constant tired feeling, coition very painful, and followed by a show, leucorrhœa, prolapsus and retroversion, from one to three or four metrorrhagias every month, besides a profuse menorrhagia. Has lost all nervous energy, and become melancholic, despairs of ever being well again, and even wishes to die, although naturally of a sanguine lively temperament, and generously endowed with this world's luxuries. In this condition she went to New York for treatment, and after a few weeks treatment her physician advised an operation. Preferring, however, to have it performed at home, she returned, and on the 26th of January, assisted by Dr. Adams, of Harriston, and Dr. W. Emory, of Galt, the operation was performed as in Case I, with the exception that silver wire sutures, secured by clamping with perforated shot, were used instead of the catgut, as there is some danger of the latter becoming absorbed before union has become firm. In this case five sutures were required, and when on the twelfth day they were removed the union was perfect. In three weeks after the operation, the contour of the cervix and os was so perfectly restored that they might very easily have been mistaken for those of a virgin. It is now several months since the operation, during which time she has not had a single hæmorrhage nor profuse menstruation. The leucorrhœa has disappeared, coition produces no pain. As evidence that the cervical canal has become natural, a few days ago while making a digital examination to ascertain if the retro-version had dis-

appeared, I passed the sound without her knowledge, an operation which always gave pain before. The position of the uterus is also nearly natural. No pessary has at any time been made use of.

Mrs. S. First and only confinement, two years ago. On account of complete absence of "liquor amnii," the labor was protracted twenty-four hours, with the following history: After labor, constant hæmorrhage for over a week, so much so that she was kept perfectly quiet with vagina tamponed, and foot of bed elevated. The lochia remained sanguineous for six weeks. There was local soreness, using the syringe gave acute pain. After getting up suffered a great deal of pain of a labor-like character, seemed as though the internal organs would be forced through the vulva. Was always obliged to support the parts when ascending a stairs. After weaning babe at eight months, began to feel poorly, suffering from a constant tired feeling, constant dragging pain in back, profuse leucorrhœa, menses every two or three weeks, and very profuse, gradually grew worse until time of consultation, when she was a complete invalid. A digital examination revealed the vaginal walls greatly relaxed, and the cervix lying almost against the vulva was greatly enlarged and very sensitive, the os allowing the finger to pass in nearly an inch. The speculum revealed a typical case of complete bi-lateral laceration, with the mucous membrane of torn cervical canal thickly studded with enlarged follicles and angry looking granulations. There was subinvolution, the sound giving a measurement of four inches. On August 19th, the operation for restoring the cervical canal was performed, assisted by Dr. Cowan, of this city. Eight sutures were required to close up the rent after the necessary denuding had been thoroughly accomplished. The wound united by first intention, and one month after the operation there was not a vestige of cicatrix to be seen, the os was just large enough to admit the ordinary sound which now gave a measurement of two and three-quarters inches. The wound had righted itself into normal position, and the vaginal walls were con-

tracted so as to close tightly around the finger. She has now resumed her household duties, and is in short another woman.

Similar cases might be multiplied, but enough has been given to illustrate the benefits following this operation.

Some changes have, however, since been made in the method of the operation which it may be well to state. I no longer operate as formerly in the dorsal position. But in the Sims position, using the Hunter self-retaining speculum, and instead of using from six to eight silver sutures I only use two silver sutures, one on either side of the os, and horse-hair for the rest. The advantages of the horse-hair being their easy introduction with a horse-hair needle, their easy removal, and the length of time they can be left in without inconvenience or unpleasantness of any sort. For these last improvements I am indebted to my esteemed friend and teacher Prof. H. F. Biggar, of Cleveland, Ohio. [Dr. Biggar will probably acknowledge our prior claims in the use of horse-hair.—Ed.]

OPIUM—RETENTION OF URINE.—Among the urinary symptoms of this drug we have both involuntary urination and retention of urine. It produces paralysis of the longitudinal and circular muscular fibres of the bladder, thus causing retention, while at the same time it blunts the sensibility of the mucous membrane, especially of the neck, to such a degree that the fullness is not felt, and as a natural result the urine may dribble away without the patient knowing it, though the bladder be full and the urine in quantity retained. A condition of this kind is frequently met with in acute disease; in fevers; in nursing children, after passion of the nurse; and especially in paralytic conditions after parturition. It is doubtful if any remedy in the *Materia Medica* is so often called for in this latter condition as Opium, and when the patient complains of nothing but fullness and inability to urinate, a dose of the thirtieth or two hundredth potency will act like magic and allow the catheter, the dread of so many patients, to remain in its cace.

H. C. A.

THE HOMOLOGY OF THE HYMEN.

Pozzi's paper ("Arch. de tocol.," April, 1884) was suggested by two singular cases which appeared in his service at the Lourcine Hospital, in one of which, that of a girl nineteen years of age, there was absence of the vagina, uterus, and ovaries; in the other, a pseudo-hermaphrodite male, there was perineal hypospadias. The studies of the author led him to the following conclusions, which differ materially from those of previous anatomists and investigators. 1. The hymen is an appendage of the vulva and not of the vagina. It is developed from the uro-genital sinus, which also forms the short vestibular canal which constitutes the margin of the vaginal canal. In both of the cases in question there existed a hymen and a vestibular canal, but in neither was there a vagina or a uterus. 2. It is, therefore, by a false homology that the term *bulb of the vagina* has been given to that portion of the vagina which was supposed to correspond to the bulb of the urethra in the male. The spongy bodies of the urethra are not comparable to the *labia minora*. In the author's hypospadias case there were both well-marked nymphæ and spongy bodies, though atrophied, under the form of the bridle or vestibule. The spongy bodies are the result of a special formation along the border of the uro-genital sinus. In the female, and in a subject of hypospadias, we have, externally, the development of the labia majora; internally, that of the nymphæ. 3. In the female, between the clitoris and the meatus, we find a small bridle, which the author proposes to call the muscular bridle of the vestibule, which is marked with a median groove, and is divided below so as to surround the meatus urinarius. When the hymen is present it appears to be a continuation of this membrane. 4. The study of the balano-urethral bridle, as in cases of hypospadias, shows its connection with the atrophied bridle of the female vestibule. The hymen in the female is the analogue

of the whole or a portion of the urethra in the male; it is the bulb in an embryonal condition, non-erectile and membranous, at the entrance of the vestibular canal, a vestige of the uro-genital canal. 5. The analogy of the glands of Bartholin in the female with those of Méry or Cowper in the male is readily traceable. The greater relative length of the ducts in the male glands is noticeable and its object can be readily understood. 6. The muscular bridle of the vestibule in the female is the remnant of the anterior or cylindrical portion of the spongy bodies just as the hymen is the remnant of their posterior or ovoidal portion.

SOCIETY PROCEEDINGS.

THE MASSACHUSETTS SURGICAL AND GYNÆCOLOGICAL SOCIETY.

This Society held its annual meeting in Boston, Dec. 10th. The officers elected for the ensuing year are: President, N. R. Morse, M. D. of Salem; 1st Vice-President, H. K. Bennett, M. D. of Fitchburg; 2nd Vice-President David Foss, M. D. of Newburyport; Secretary, L. A. Phillips, M. D. of Boston; Treasurer, J. H. Shuman, M. D. of South Boston. Six new members were elected, making the present membership more than one hundred. Correspondence relative to the National Hospital at Washington, and regarding the publication of the papers of the society was laid on the table without action. President H. A. Houghton read an address upon the "History, Development and Progress of Gynæcology as a specialty" which was followed by the following papers, viz:

"Cystitis," by H. M. Hunter, M. D., of Lowell.

"Vaginitis" by O. S. Sanders, M. D., of Boston.

"Hæmorrhage from Polypi," by G. F. Forbes, M. D., of W. Brookfield.

"Operation for Prolapsus of Bladder," and "treatment of Abortion at third or fourth month," by G. R. Southwick, M. D., of Boston.

"Cystitis," by W. P. Defriez, M. D., of Woburn.

"Physical Examinations, Local Applications and Pessaries. A reply to Dr. Minton's propositions," by D. B. Whittier, M. D., of Fitchburg.

"Cystitis," by A. M. Cushing, M. D., of Boston.

"A case of Gastro-Intestinal Catarrh following Childbirth," by J. H. Sherman, M. D., of So. Boston.

Very little time was left for discussion of the papers, and a general desire was expressed for a different arrangement at the next meeting, whereby more time can be allowed for discussion. Erich's self-retaining Vaginal Speculum, Ludlam's Uterine Repositor, and a set of Tubular needles were exhibited by Dr. Phillips. Satisfactory results from the use of Hydro-Chlorate of Cocaine in operations upon the uterine cervix were reported by Dr. Southwick and Dr. Phillips. Adjourned to the 2nd Wednesday in June.

L. A. PHILLIPS, Sec'y.

NEW PUBLICATIONS.

CLINICAL AND PATHOLOGICAL OBSERVATIONS ON TUMORS OF THE OVARY FALLOPIAN TUBE, AND BROAD LIGAMENT. By Alban H. G. Doran, F. R. C. S., London, Eng. 190 p. \$2.00, Henry Kimpton 82, High Holborn, London, W. C. England.

This book is clearly what the author represents in his preface, a special work within a special branch of medicine; a part of the gynæcological practice, classified in Europe with the department of surgery and should be so in America. The day is not far distant when all abdominal operations will be regarded as a special field in surgery more than a branch of gynæcology.

This work of Mr. Doran's is intended for the pathologist and special operations in abdominal surgery and as such is very interesting and instructive. The author has had the best of advantages on the staff of the Samaritan Hospital and has collected many rare specimens that are illustrated in his work. He has avoided subjects that have been under discussion for years and has made an honest effort to present clean and fresh matter for consideration. He has had the benefit of the advice of Drs. Henry Savage, C. H. Ritchie, Thornton, T. Spencer Wells and Bantock, all of that hospital and all recognized authorities in abdominal surgery, or ovariotomists. We heartily recommend the work to those interested in this special field of surgery.

PRACTICAL MANUAL OF DISEASES OF WOMEN AND UTERINE THERAPEUTICS. By H. Macnaughton Jones, M. D., London England. 408 pages—price \$1.50.

This work is a complete and concise treatise on gynæcology and is, as the author claims, intended for the student and general practitioner.

In the preface, the writer states, as his reason for writing a book of this character, that "many years of experience, both as a clinical teacher and lecturer on obstetrics, had taught me that students rarely mastered the more comprehensive gynæcological treatise. How inadequate is the time at the disposal of a lecturer to complete a satisfactory course even on obstetrics, let alone gynæcology, in one winter's session."

The chapters on "how to make a local examination" and treatment, with the various formulæ for local application, the manner of employing the sound and probe, and last but by no means least, instructions for introducing pessaries are indeed very instructive.

The tables on the character and importance of vaginal discharges, covering some seven pages, is a new feature in gynæcological works and will be especially appreciated by our school. The work, in fact, represents the gynæcological practice of the Allopathic school up to the present period. Henry Kimpton, Medical Bookseller, 82 High Holborn, London, W. C. has the sale of the book at 5 s. 9 d.

RACHEL T. SPEAKMAN, M. D., formerly of Battle Creek, Mich., is now resident physician, and professor of physiology and hygiene, at Wellesley College, Mass.

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4. Personal controversies, not being of interest to the profession in general, cannot be published. Explanations may be made through the editor. This rule will be strictly adhered to.

Owing to pressure of business in our printing office, and the increased number of pages, the January issue of *THE ADVANCE* has been unavoidably delayed. The February number will be promptly issued, and will contain some illustrated surgical articles of great interest. Subscribers in arrears will confer a great favor on the publisher, by examining the printed address on the journal and promptly remitting amount due. Subscriptions are paid to date on printed address.

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AND

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COCAINE.

(ERYTHROXYLINE.)

Cocaine Hydrochlorate

(MURIATE OF COCAINE.)

**COCAINE ALKALOID,
COCAINE CITRATE,
COCAINE OLEATE,
COCAINE SALICYLATE.**

The remarkable discovery announced last October that a solution of muriate of cocaine applied to the conjunctiva of the eye produces complete anæsthesia of that sensitive membrane, has created a demand for the salts of this alkaloid which it has been difficult to supply.

Coca leaves are scarce, and held at a very high figure, and the scarcity is likely to continue for some time. We have, however, been fortunate in securing a supply of leaves of good quality, and are now in position to fill all orders for the alkaloid or its salts.

The extraordinary power of cocaine salts to obtund the sensibility of the delicate membrane of the eye has suggested trial of its powers on other mucous membranes, as those of the throat and respiratory passages, the urethra and genital apparatus, etc., and the results have exceeded the most sanguine expectations. Its almost instantaneous effect in relieving the excruciating pain in otalgia, in some cases of supra-orbital neuralgia—probably of reflex origin—and in toothache, where the nerve is exposed, should secure for it a place in the pocket medicine case of every physician.

Cocaine salts, however, have no appreciable action on the deeper tissues unless given by hypodermic injection, but when so administered are capable of affording great relief in some painful affections. The medical journals are full of accounts of the triumphs of this new local anæsthetic, which is sure to hold a rank hereafter in the materia medica with opium and quinine.

We offer the following preparations of cocaine:

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THE AMERICAN HOMŒOPATHIC JOURNAL
—OF—
OBSTETRICS AND GYNÆCOLOGY.

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NEW REMEDIES IN GYNÆCOLOGICAL PRACTICE.

BY LESLIE A. PHILLIPS, M. D., Boston, Mass.

The use of new remedies in any and all departments of practice—unless they have been previously well and thoroughly proved and their pathogeneses thus established, is at first, a matter of simple experimentation, their therapeutic value being uncertain and unknown. Whether we are justified in making use of them under such conditions, especially upon patients in private practice, is a question concerning which there is a wide difference of opinion. Some insist that only the well-proved and reliable remedies should be prescribed under any circumstances, while others advocate the free use of any and all which offer any promise of benefit. It should be remembered, I think, that very rarely, if ever, are reliable provings made of *any* substance, until some one has experimented with it, and reported favorably as to its effects, and generally, not until some marked and special virtues have been clinically demonstrated. So, for one, I feel

justified in making use of some remedies which are very little known, with a view to adding my observations to those of others, and thus help to establish a basis for a careful proving of the same, or to prove it unworthy.

That we are more especially warranted in this course in the department of Gynæcology, cannot, I think, be reasonably denied, for the reason that as yet, very few even of the old and familiar remedies, have been proved by *women* competent to determine and describe their effects upon the reproductive organs. Nearly all symptoms relating to the special organs of women, whether of old or new remedies, as contained in any of our works on *Materia Medica*, are, at best, only clinical observations, such as we may ourselves make, by using and carefully noting their effects. That we labor under a great disadvantage on this very account, all must admit who realize the value of the real homœopathic indications, i. e., the correspondence of symptoms actually produced by the drug in a healthy prover, to those noted in a patient. And I must be allowed again, as I have several times before, to appeal to the women in the profession to consider the duty which lies so plainly before them. Though a task from which all naturally shrink, because it involves discomfort and self-sacrifice, yet *only* by thorough, carefully observed provings, have the real homœopathic indications of any drug ever been ascertained, and only by this means *can* they be; and inasmuch as *only* women can learn by provings, what we so much need to know in order to treat most successfully the diseases which cause so much suffering among women, and as no others are so well qualified, so entirely and unquestionably competent to make a reliable, scientific proving of the various remedies, with reference to their effects upon the special organs and functions of woman's sexual life—we cannot too urgently appeal to our sisters in the profession, or over-estimate the importance of the service they are called upon to render, a service not only for the benefit of the profession but even more for the good of women—a cause which is to them generally, I

think, more dear, even than homœopathy or their profession. Hoping that this much needed work of proving will be undertaken, I want to make one request regarding it, viz: Let the observations upon the effect of any drug, include the *objective* as well as the *subjective* symptoms, note the changes, if any, in the *condition* and *function* of each organ, as carefully as the sensations and impressions.

While we are waiting for the women to do what we cannot do ourselves, we must study from a clinical standpoint, and by noting and comparing results, learn how to use our remedies to the best advantage and with the best results possible. To this end, and that others may supply in return from their own observations what they find wanting in mine, I offer the results of my study of a few drugs but little known except to those who have used them as I have, experimentally, but which I believe will prove of much value in the treatment of women's diseases.

Boracic Acid shall receive first consideration as it certainly ranks among the very first in its usefulness. Its action is four-fold; deodorizing, disinfectant, antiseptic and therapeutic. As a deodorizer and disinfectant I prefer it to any other for offensive, irritating or corroding leucorrhœa or lochia; being bland and soothing as well as odorless it is more agreeable both to the patient and those about her, than Carbolic Acid or any of the active astringents more commonly used for this purpose. As an antiseptic I believe it to equal any other in its power to destroy the germs, and render innocuous the poisonous secretions with which it may come in contact, while it is far less poisonous in itself, than others; in fact I think it can scarcely be called poisonous at all.

Now, if as maintained and firmly believed by many, all cases of pelvic cellulitis and other inflammatory difficulties, are the result of absorption of septic material through wounds, abrasions or otherwise exposed surfaces, we should carefully guard against this, not only after confinement, but when we find erosion or laceration of the cervix, or ulceration, fissure or any other solution of continuity; and this

will include a large proportion of the gynæcological cases. Whether this theory be accepted or not all will agree that if by use of a substance in itself harmless and unirritating, but rather healing, we can avoid the dangers arising from this source, we should not ignore it. Such a substance I believe we have in Boracic Acid, and for a considerable time I have made it an ingredient of all local applications to the vagina or uterus with most satisfactory results. Furthermore I have found that it cleanses, and decreases the discharges from the mucous membrane, reduces inflammation and pain, deodorizes and disinfects, as before stated, and by its antiseptic or preservative power, makes the retention of any application practicable for a much longer time, as no offensive discharge or odor is developed as is the case without it. It is generally sufficient in itself to relieve and cure most cases of vaginitis whether simple or specific, all symptoms of gonorrhœa disappearing rapidly under its influence applied locally. In all the glycerine used as a menstruum for local medication, I dissolve as much Boracic Acid as it will take, which is about 16 or 18 grains to the oz. and to this add the desired drug in varying proportions according to circumstances.

There are some to whom glycerine is irritating and uncomfortable; with such I have used, with excellent effect a powder composed of Boracic Acid and Lycopodium, equal parts triturated together. This I apply by insufflation, after cleansing thoroughly with swabs of absorbent cotton. This powder I have sometimes used in cases of endo-cervicitis with more or less erosion, blowing it into the canal before applying the glycerole, and believe it has aided in effecting rapid cure. Besides its use locally, I have found it my best remedy for membranous dysmennorrhœa given in the 1x trituration, at the same time applying glyceroles to the cervix. I think this condition will be more surely corrected, by this, than by Borax or any other one remedy. It has cured for me some old chronic and severe cases.

Eucalyptus globulus has received some attention of late but still remains an unknown quantity to the majority of phy-

sicians. This had been used and advocated as an antiseptic, but its strong odor and the stinging, burning sensation produced by it, render it less desirable for this purpose than the Boracic Acid. This antiseptic quality however, adds to its value as a therapeutic agent when applied locally, and possibly even when administered internally, and it is a question whether its recorded service in malarial difficulties and diphtheria, is not due to this power over germs and poisonous elements. My first use of it was as a remedy for urethral carunculæ for which I had seen it recommended, given internally it produced no perceptible effects, but I have since used it for this condition with complete success, by applying it locally to the tumors, in the form of a glycerole. I saturate a little roll of cotton, which is wrapped around a small applicator, and introduce it into the urethra just as I would into the uterine cervix, and order it to be retained until evacuation of the bladder is demanded, when it must of course be removed. As a remedy for profuse catarrhal discharge from any mucous surface, especially when due to an acute inflammation, I believe it is second to no other. As related to endometritis and other causes of leucorrhœa the following indications lead me to use it both locally and internally, viz.

Profuse catarrhal discharge from enlarged swollen cervical papillæ. Corroding or offensive leucorrhœa with urethral irritation. (Profuse mucous discharge from the endometrium, i. e. corporeal endo-metritis—urethral caruncles) especially serviceable in individuals having a tendency to catarrhal troubles generally from slightest exposure to cold.

For local use the fl. ext. should be diluted with glycerine, nine parts of the latter to one of the Eucalyptus. Internally, I have always used the 1x dilution. I certainly hope others will give us the indications which lead them to use this drug, which I believe will prove to be of exceptional value.

A remedy worthy of study, in my opinion, is known and sold as "*Pinus canadensis*," but as it is made from the bark of the *Hemlock* or *Abies canadensis*, it would seem that it

should properly be named *Abies* not *Pinus canadensis*. My experiments have been made entirely with S. H. Kennedy's Concentrated Extract, and only as a local application. I do not claim to have obtained any well-defined characteristic indication for its use, but still, think the results obtained were due to something more than the astringent action of the Tannic Acid which it contains. I have used it with very gratifying success in cases of erosion of the cervix uteri consequent upon a prolapse, which causes undue pressure and friction of the cervix against the perineum, and accompanying this as is so frequently the case, a flabby lax condition of the vaginal walls. Under its influence the tissues become firmer, the mucous membrane less sensitive and the prolapsus which is in such cases due chiefly to the laxity of these supports of the uterus, is itself relieved. This result I have secured in several cases, without the least unpleasant effect except perhaps the staining of linen which is liable to occur unless special care is taken.

I have also used it with very satisfactory results in some cases of specific gonorrhœa vaginitis, as well as in simple catarrhal inflammation with profuse leucorrhœa. In all cases I have used this Kennedy's Extract with glycerine in proportions varying from 1-10 to 1-2, saturating a large pledget of absorbent cotton, which is placed behind and under the cervix so as to form a cushion upon which it may rest, thus serving the double purpose of relieving the uterine ligaments, and bringing the remedy in direct contact with the membranes where by absorption, its therapeutic effects are produced. In this connection it may not be out of place to refer to the objections and criticisms, often severe and bitter, in which the class of physicians assuming to itself orthodoxy, and special purity in Homœopathy, so frequently indulge, against any and all *local* applications in the treatment of women's diseases. The *fact* which the experience of nearly all, if not every gynæcologist has demonstrated to his own satisfaction, at least, that by their aid cures are more rapidly and more surely effected, this in itself, *ought* to be an

all-sufficient reason for their use; but aside from this, and inasmuch as these critics make the *manner* of curing more important than the fact, I would ask if it is not demonstrated that drugs will produce their specific characteristic effects whether administered per oris, per vaginam, subcutaneously or otherwise, so be it is introduced into the circulation, or comes in contact with nerve filaments.* And if we select our remedy upon the basis of "the totality of symptoms," is it not just as strictly and purely *Homœopathic*, whether applied in one or another or several ways? I maintain that it is, and believing as I do in the reliability of the principles of Homœopathy, I am confident that our best remedy in any case is that homœopathically indicated, and that it should be applied in the manner, and form which "will do the most good." Let me again remind you however, that in the field of gynæcology, the standard of comparison, i. e. the pathogenesis even of the old familiar drugs is generally wanting or very imperfect, making it a necessity for us to experiment, or study the remedy from a clinical stand-point; hence I deem it not only our privilege, but our duty to use and note the effects of any promising material, and by comparing and aggregating our observations secure the best knowledge of them we can, until such time as a thorough proving shall be made by women competent to perform the task. When we have that we shall not need to experiment.

ROUGH ON ALLOPATHY.—To get even with their doctors, two families in Atlanta recently ornamented the graves of their dead children with bottles containing what remained of the medicine prescribed by the attending physicians. The bottles bore the druggists' labels, the prescriptions and the names of the physicians.—*New York Sun*.

*Hahnemann in his *Organon* says: "Every part of the body, endowed with sensitive nerves, is capable of receiving the influence of medicines, and transmitting them to all other parts," and mentions the "rectum and genitals" as equally susceptible to medicinal effects, with the mouth and stomach, and denuded surfaces *more so*.

DISEASES OF WOMEN AS A CAUSE OF INSANITY.

H. H. CRIPPEN, M. D., London, England.Late Assistant to Dr. Phil Porter.

The cranial ganglia, although the organs of consciousness are subject to the same laws, the same mutual relations, and the same coordinative principles that govern all other ganglia. Thus they are affected by the same reflex conditions as conveyed by nerves acting through periferal irritation and again are under those profound influences produced by disturbances of the circulation through the sympathetic system. Indeed, this question of the sympathetic theory takes an active part in the whole series of combined spasmodic, convulsive, and mental affections; the law of sympathy being in effect that concerning the coordination of the vascular factors. The starting point, or, at least, almost every known form of insanity, is in vasomotor disturbances, by which the amount of intra cranial blood is altered; and the fact should be recognized that a disordered mind is the result of a disturbance of vascular relations; a scarcely appreciable increase or diminution of blood supply to the brain, leading to mental derangement of some kind.

If to these considerations we associate the fact, that in some parts of the body certain areas stand in such relation to the nerve centres as to produce a decided disturbing centric action by irritation of the periferal endings of the nerves they contain, we can clearly perceive the mutual regulative dependence of the cranial centres and the pelvic organs. The importance of these reflex influences upon central nervous action cannot be over estimated, for the amount and force of the periferal influences which the generative organs bring to bear upon the central nervous system, are greater than any that may proceed from a functional disturbance of any other organ.

In beginning a discussion of the relationships of insanity to abnormal conditions of the female generative organs, it will be found much easier to observe some order, but no especial classification can be followed other than that as to certain crises, with the period between, through which a woman passes. Thus, we may say, that there is an insanity of development occurring at the time of puberty, an insanity of maturity, more especially consequent upon abnormal conditions and an insanity at the close of maturity, the so-called climacteric.

The first period, the age of puberty, is of especial interest, for the beginning of menstruation constitutes one of the critical points in the life of a female, and exerts a powerful influence over her health and mortality. The beginning of the period of menstruation, marked as it is by such profound changes in constitutional, as well as local development, sometimes leads to very decided conditions of mental derangement, if abnormalities supervene, or if the physiological functions be delayed. The following case is marked illustrative of this last:

Miss M——; age fifteen. Admitted into the ward Jan. 23.

Previous History.—Moderate education; has had scarlatina and measles, both benign. Has never menstruated. Maternal grand-aunt insane; grandmother died of hemiplegia and imbecility. The earliest symptoms of insanity ensued last June, when she became the subject of dullness and taciturnity, passing into a condition of acute mania. She became very restless; said that people were going to kill her; that her brother had given her heart disease and that he wanted to kill her. She remained in this condition until her admission. The first examination revealed no hallucinations but delusions that her relatives are against her, that she is about to die, that she can not go to heaven, etc. She is tall, very thin, light haired; has sharp features and is rather phthisical looking. Very incoherent and wandering. Noisy at night; takes food fairly well.

Jan. 25.—Makes so much noise and is so restless that she has been removed to the refractory ward. Incoherent, almost constantly talking nonsense. Knows where she is, however, and wants to get out.

Feb. 16.—Still incoherently and continually rambling on and can not stop to answer questions. Has no self-control and is rather mischievous.

Feb. 22.—Much the same, but not so noisy.

Feb. 28.—Not so noisy except at night; is constantly losing flesh.

April 25.—Better in health and general appearance. Mental state varies considerably from day to day. Sometimes she is more composed for twenty-four hours, then again talkative and incoherent, her language being sometimes very foul.

June 23.—Menses have appeared for the first time.

July 25.—Improving rapidly. Removed to the convalescent department.

Aug. 23.—Discharged cured.

The treatment from the first was directed towards establishing the menstrual function, with the satisfaction of seeing her restored to health on its appearance.

These conditions of mental derangement at this period of life are decidedly more prone to appear in young ladies whose childhood has been devoted to exercising the mental faculties in acquiring the usual refinements of civilized life, all of which are obtained in a comparatively quiescent state of the muscular system, rendering them in a high degree susceptible to nervous irritation, particularly at the time when womanhood is reached. At this time the genital organs, which have hitherto exercised but little influence over the general system, are developed, becoming capable of performing their functions; but should the physiological change become perverted, there may ensue an exaggerated impressionability to all excitations from without and reflection from within. So that it is in the hot house plant that

this sensibility is greatest, the girl of precocious education, the slave of fashion and late hours, with implements of torture to keep the shoulders straight and the waist within bounds, the sexual instinct being developed at the cost of the already enfeebled body; and thus excessive or irregular and painful menstruation occurs, in a girl ill-fitted to bear any extra strain on her strength, with disastrous results to the mental stability.

The chief feature of the mental derangement occurring at the beginning of menstruation is the impulsive or emotional nature of the disturbance characterized by feelings of exaltation, though the opposite, a depression of feeling of unworthiness, may exist. The emotional morbid impulses are usually in the form of moral perversion, such as pyromania, kleptomania or erotomania.

Coming now to the consideration of the period of maturity, we are at once confronted with a difficulty in obtaining statistics; this is necessarily so; the difficulty in obtaining careful and repeated examinations is an obstacle yet to be overcome. Indeed in many cases such repeated examinations but serve to direct the patient's attention to herself and establish a hypochondrical condition. But, there are some conditions that are unmistakable, and in which, treatment properly directed will produce beneficial results. The mental derangement may be either started by ovarian or uterine disorder, or may exist as a train of symptoms in direct relationship to the seat of the disorder. A slight derangement of the physiological processes of the generative organs may only produce a hysterical condition, but this may not be the stopping point; these abnormal conditions of an almost unnoticed congestion of the brain are prone to end in promptings to the commission of absurdities or even crime.

Women are easily upset by sexual troubles, and the periods of pregnancy, parturition and lactation, add greatly to the danger they run of becoming insane. The action of

these causes in producing a nervous disturbance is simple enough. During the earlier months of pregnancy we find the mental derangement ensuing through the worry, physical and mental, attendant upon the condition. The insanity after parturition may follow from the condition of shock, from loss of blood, or from an exaggeration of the pains of labour. Following lactation, the unstable mental condition may result from the onset of milk, or may result from exhaustion after long continued nursing.

But aside from such causations, which we may consider but an exaggeration of physiological conditions, there are a large proportion of nervous disorders occurring as the result of purely abnormal conditions. Flexions, versions, tumors, or over excitement of the generative apparatus, by narrowing or occlusion of the cervical canal, are a constant source of reflex irritation of the nervous system producing hypochondriasis and various forms of mania, to say nothing of motorial and functional disturbances.

The following case of mania from irritation of a foreign body in the vagina* is illustrative of such causes of mental derangement.

"J. W.—No. 560. A laundress, aged sixty-one; stated to have been insane four months. Has made many attempts to destroy herself. Is wild and restless, pulling off her clothes, tearing her hair; says she is the queen of heaven. Is very violent, swearing and incoherent. Pulse small and quick, head and skin perspiring and not hot, desire for food voracious, sleep broken. A month after admission she had a febrile attack, with severe lumbar pain. This occurred five times, producing great languor and debility causing her to keep her bed. Various means of treatment were adopted, without effect. The patient became very weak, with flying pains all over the body, and at length she could not for a long time leave her bed, and her life seemed in imminent danger. Five months from her

*Manual of Psychological Medicine. Bucknill and Tuke.

admission, a disagreeable purulent smell was observed about her, and on seeking the cause, an offensive vaginal discharge was observed, which she had doubtless taken measures to conceal. We desired the assistant medical officer to examine the vagina with the speculum. This he did in opposition to the strenuous efforts of the patient, and reported to us the existence of extensive malignant disease, the cervix and part of the body of the uterus were found occupied by a large, ragged, foul ulceration; the parts around of a greenish black color; and the whole covered with a most offensive discharge. Having ordered the use of chlorinated injections, after some days we used the speculum ourselves; the patient again resisting most vigorously and requiring to be held in position by nurses. We found a large ragged ulceration occupying the cervix uteri and upper end of the vagina, lying across which appeared a great piece of wood. This we easily removed with the finger and found to consist of a child's toy, *a wooden trumpet*. When the first examination had taken place this thing had been concealed by granulations and discharge. The patient of course strenuously denied having introduced it, and it is certainly singular that at her age, she should have resorted to such a method of self abuse. After the removal of the irritating cause the vaginal discharge ceased, and the patient began to improve; but her bodily health had been so broken down that it took several months to restore it. She was discharged recovered, twelve months after admission."

This case is quite clearly illustrative of the close relationship of irritation of the generative organs to an unstable condition of the mental faculties. From investigations at the Bethlehem hospital I found that out of 520 cases of female insanity, 125 come under the heads of puerperal, climacteric, miscarriage, uterine and ovarian disorders and suppression of menses as causes. So that nearly 25 per cent. of the cases are due to derangements of the reproductive organs.

The period of cessation of the menstrual discharge is also one which exercises great influence over the health of the individual, and especially so far as the mind is concerned. It is often the determining agent when hereditary or other predisposing causes to mental disease exists, and even when there is no such predisposition acts as its own immediate cause. The period of the menopause is already that of degeneration, the destructive processes of the body now exceed in a proportion the formative, so that occurring as it does during a failure of the nutritive processes of the brain it is a most prolific cause of mental alienation. If to this be added abnormal conditions, menorrhagia, metrorrhagia, or it may be a fibroid tumor, nothing is more favorable to an unstable condition of the mind.

This is the age of melancholia, hypochondriacal mania, characterized by the existence of morbid fear and a tendency to commit suicide. Quite often there are various forms of emotional disturbances, or of perversions of the appetite, which are a source of distress to friends and relatives. Associated with a group of hypochondriacal ideas, we often find sense perversions, hallucinations of smell, and alternate feelings of heat and cold in parts of the body.

Nothing can more forcibly point out the condition of the climacteric than the following from Bethlehem.

M. C.—aged forty-five; married; has two children; youngest twenty-two. Has no family history of insanity; but her mother died of phthisis. Three weeks ago became strange in her conversation; thought some one was going to shoot her; always walking about and talking.

May 27. On admission: She has hallucinations of hearing; thought people were talking to her; these people say nasty things and lies about her. Thought she was going to be locked up; if she were to go out, some one would come with a van and clear the furniture away. Tongue very dry and much coated; appetite bad; has to be fed. Ceased menstruating during the last three months.

June 5. Her tongue is very much coated but is not so dry as when she came in. Still has to be fed.

June 16. Still troublesome about her food and is incoherent.

June 20. Has improved in bodily health and looks well. Her mental condition is unchanged.

July 19. Mental condition not satisfactory. Will not talk and appears demented. In good bodily health.

August 23. Still very troublesome about food; will not speak and appears in a semi demented condition.

September 20. Is rather better; doing a little work and answers questions. Takes food better.

October 4. Improvement continues; writes good letters and talks quite sensibly.

October 10. Transferred to convalescent department.

November 7. Discharged cured.

This is the usual history, first morbid ideas, then a hypochondriacal condition, developing into active melancholia or into melancholia with stupor. By careful examination of 26 cases of insanity at the Menopause, I find that 16 cases were cured, one died and four remained uncured at the end of a year. The prognosis depends much upon the form of mental derangement and the duration, those cases of over a years progress being usually incurable.

TREATMENT OF SLIGHT BURNS.

Dr. Cramer treats slight degrees of burns by means of compression. He applies a layer of wadding and over this an elastic bandage, so as to make firm and even pressure over the whole of the injured surface. By this means the subcutaneous capillaries are emptied in a measure of their blood, and inflammation and exudation of serum are prevented. The compression is to be maintained from three to fifteen hours, according to the intensity of the burn, and then a less degree of pressure kept up until new epidermis has formed.—*Memorabilien—Med. Record.*



LOUIS PASTEUR.

There is no member of the profession who has made for himself, by his own experiments, a greater reputation in certain directions, than Professor Pasteur. He is recognized as a second Jenner—of vaccination fame—and although his deductions are not any more readily accepted than were Jenner's, he nevertheless, is demanding a conspicuous place in medical and other scientific literature,

that has not only won the respect of his confrères, but of the French government, which made an appropriation of some six thousand dollars to assist him in his labors.

The professor is now sixty-three years of age, and although he had a severe attack of paralysis fifteen years ago, he at present enjoys comparatively good health.

In one of his first works he discovered that crystallized organic substances, although having the same chemical properties, have decidedly different physical properties, specially in relation to the refraction of light. He made many valuable discoveries in relation to fermentation, and was able to prove that the process of fermentation, that is, the conversion of sugar into alcohol and carbonic acid, is due to the vitality of the yeast yerm. In this matter the celebrated chemist, Liebig, was his opponent, but Pasteur's experiments were so numerous and new, and at the same time so absolutely exact, that his success was assured. He finally conceived the idea of making experiments to ascertain whether yeast germs, fermentation, mould, etc., could originate of themselves in fluids. His experiments proved beyond any doubt that this was not possible, and thus settled this question of long standing. He also discovered a method of preserving wine and beer by heating it for about thirty minutes to from 46° to 48° C., whereby the yeast germs are destroyed and prevent further decomposition of the liquid.

Since 1870 Pasteur has given all his attention to contagious diseases, such as anthrax, chicken cholera, and rabies of dogs. All these diseases are caused by microbes, and he claims that by inoculating part of the poison, in small quantities and very much diluted, into the system, a person is less apt to be affected by these diseases than those who have not been thus inoculated.

Toussaint previously made experiments with the blood of animals suffering from anthrax, but Pasteur has succeeded in raising anthrax bacilli in a drop of blood, and by

preserving the germs upon certain substances, their strength as a poison was diminished to such an extent as not to cause any disease. Injections of this diluted poison protected animals to such an extent that very few suffered from anthrax where formerly entire herds were killed.

The latest experiments Pasteur has made are in relation to the rabies of dogs, and during the first months of last year he notified the Paris Academy that by inoculating dogs with microbe organisms they have been protected from the effects of bites from rabid dogs. The results of these experiments are so well known that they need no further mention here.

NEUROSTHENIA--OÖPHORECTOMY.

PHIL PORTER, M. D., DETROIT.

CASE I.—Mrs. B—, æt. 32, of French nativity, has had two children, always suffered pain in both ovarian regions since puberty and especially so when pregnant—with one child the suffering was so severe abortion was produced at fifth month by her attending physician. Pain complained of in almost every organ and part of the body. In other words there was an “excess of nervous irritation” all over the entire system.

On examination, we found a lacerated cervix and perineum which was closed up, but producing no relief from the neurosthenia. Two months later we suggested oöphorectomy, which was acceded to and both ovaries were removed. Both ovaries were found very much inflamed and enlarged as well as both Fallopian tubes. The uterus was also enlarged to nearly twice its normal size. The ovaries were removed by abdominal section, the clamp, serrated scissors and cautery. No bad results followed the operation and the patient, now nearly a year since the operation, calls herself well.

CASE II.—Mrs. O—, æt. 29, Irish descent, delicate nervous organization, sensitive nature, acute susceptibility, suffered with pain in right ovary since puberty. Came under our treatment last July from Emmet's New York Sanitarium. She presented many reflex or sympathetic symptoms as well as local pelvic disturbances which were attributed to a disease of the right ovary. Dr. Emmet had diagnosed an enlargement of that ovary with a thickened condition of the broad ligament on that side. The doctor had operated on the meatus several times, "button-holing" it, as he describes the operation, for acute vesicle irritation. On examination we confirmed his opinion and added to it, that we thought the right ovary the seat of a tumor. Inasmuch as the patient had but recently been converted to Homœopathy, she desired a trial of remedies rather than resort to surgical measures at once as advised by Emmet. Sepia covered the totality of her symptoms and she was placed on that remedy commencing with the higher attenuations, gradually going down to the 12x with but little relief. At each menstrual epoch her suffering was frightful, and in October she asked for the operation. She presented anything but a favorable case for such a severe operation, only weighing ninety pounds, very weak and much emaciated, but with lots of woman's pluck and determination.

We placed her in the allopathic sanitarium here in Detroit and operated by abdominal section, removing a myoma about the size of a walnut. The right Fallopian tube and fimbriæ were atrophied so they looked not unlike a small angle-worm. The peri-uterine tissue was all more or less infiltrated and indurated. The ovarian tumor was removed by the same method as in the other case and the abdominal wound treated as in any laparotomy. She made a rapid and complete recovery and is enjoying perfect freedom from pain.

GYNÆCOLOGICAL EXAMINATION.

We reprint the following list of questions that were given to the graduating class in the Homœopathic College at San Francisco, Cal. The average percentage, taking 100 as the maximum, was 80. How many of our practitioners could pass as well?

1. Give the different methods for gynæcological examinations.
2. Mention different positions for making examination, with description of each.
3. When may you, or may you not, use a uterine sound or probe, and how is it to be used?
4. What means are at your disposal for examination of the uterine cavity, and how is it done?
5. In case of the existence of a tumor of doubtful character within the pelvic or abdominal cavity, what course may be followed in order to aid in making a diagnosis?
6. How is a catheter to be used?
7. For what purpose and how are vaginal injections employed?
8. Give the method of making local applications of medicinal agents to the uterus or vagina, and state why such are needed.
9. What is a tampon, and its use?
10. Describe the different displacements to which the uterus is liable, and some of the principal accompanying symptoms.
11. Describe the method for dilating the cervical canal, and state under what circumstances it is necessary.
12. Give the methods of replacing a displaced uterus.
13. What is the normal length of the entire unimpregnated uterine canal, and also of the cervical canal?
14. Give the anatomical construction of the uterus, and its relation to other parts of the body.
15. What are the irregularities of menstruation; give symptoms.
16. Give a few remedies, not less than six, for the different irregularities of menstruation, with special indications for their selection.
17. Describe the mammary gland, and give its anatomy.
18. Having, as you may think, fitted a pessary, what means are you to employ to ascertain if it is all right?
19. What instructions should accompany the introduction of a pessary?
20. What will be your duty after having left a pessary in the vagina?

ABSTRACTS OF THE MONTH.

RETROVERSION WITH CONGESTION

Dr. I. B. Runlin, in a clinical lecture published in *Medical Times* stated: This woman is unmarried, 21 years old, and for three months past has menstruated every two weeks, the flow continuing four or five days at a time. We have seen this patient before, and found the uterus out of place. She has menorrhagia, consequent upon congestion due to displacement. She had been in perfect health until, during one of her menstrual periods, by some strain or fall, the uterus was thrown backward. Sometimes a fall backward will cause such a displacement of the womb, and the organ remaining misplaced, will become congested from interference with its normal circulation.

If the uterus has not been retroverted very long, it can be thoroughly replaced, if the patient be otherwise in good health, and will sometimes remain in position. It is better to try a light tampon before resorting to the use of the pessary. Still, unless the case be very recent, it is rather the exception to find the uterus remain in its normal position after being replaced. This patient says that since she was here before, the bearing-down pain from which she had suffered had disappeared, and also the leucorrhœa. She has not yet passed a menstrual period since the displacement was reduced. Should the uterus not fall when it becomes congested at the monthly periods, and when she stands and walks, we may feel confident that it will remain reduced without the introduction of a pessary. It is better, however, that the patient retain the recumbent posture, on the bed or sofa, during the period. She states that she has been relieved of obstinate constipation since she came here for treatment. She had been in the habit of taking cathartics to effect a movement from the bowel. The constipation was due to pressure of the displaced uterus upon the rectum

behind, interfering with its normal functions. All this was relieved as soon as the uterus was thrown forward. In this case it was impossible to replace the uterus without the aid of the sound, which I consider justifiable *if used very carefully*. It is always better to do without it, if possible; but it is useless simply to raise the uterus a little and allow it to drop back when the finger is withdrawn. In some cases the uterus will fall into place with very slight pressure if the woman is placed on the chest and knees and the vagina dilated with Sim's speculum. Beware of attempting too much at one time, and always insist on rest in the recumbent posture, on the side, for some hours afterward, as soon as the patient reaches her home. [I regard the manner of wearing the clothing of utmost importance in treating old cases of retroversion and flexion. P.]

ELECTRICITY.

Recent investigations of the therapeutical value of electricity and the relative influence of both currents, have been reported by Dr. Cocks of New York, who lately, successively treated a case of extra-uterine pregnancy with the galvanic current, after having employed the Faradic.

The lecturer, in summing up his reports of several interesting cases, states "these cases clearly show the superiority of the galvanic to the faradic current. A better opportunity to test their relative merits could not well have been found. It has been fully shown that up to the third month faradism can destroy the foetus, but in this case, although tried thoroughly, it did not. There is no doubt that the faradic current had a very decided effect; growth was checked, tension diminished, pain lessened; but this effect was only temporary, for on the discontinuance of the treatment, evidences of life and growth speedily showed themselves. On the other hand, a moderate galvanic current (of twenty cells) failed to destroy life, and it was not

until we used a galvanic current (of thirty cells) sufficient to cause marked contractions of the abdominal and thigh muscles (the patient being profoundly under the influence of ether), both on making and breaking the circuit, that the foetus was destroyed. By a rough comparison, we may say that a twenty cell galvanic current is about equal to the full current of a one-cell Kidder faradic battery in the treatment of this condition," (pregnancy).

The editors experience with both currents, (using thirty cells for the galvanic,) in treating diseases of women, is decidedly in favor of the galvanic current. We now seldom employ the faradic. Dysmenorrhœa is especially amenable to this galvanic current.

POINTS IN THE MANAGEMENT OF DISEASES OF CHILDREN.

El Dictamen quotes the following aphorism by Prof. Ledamenda:

1. Children are like the mob; they always complain with reason, although they cannot give the reason why they complain.

2. Always look at the lips of a pale and sickly child; if they are of a deep red color, beware of prescribing tonics internally. At the outset you will congratulate yourself, but in the long run you will repent of having employed them.

3. As a general rule, a sad child has an encephalic lesion; a furious child an abdominal one; a soporific child has both, though indistinctly defined.

4. An attendance on children produces in the mind of an observant physician the conviction that the half, at least, of adult transgressors are so through morbid abdominal influences.

5. A sunny living room, a clear skin, and an ounce of castor oil in the cupboard—these are the three great points of infantile hygiene.

6. To dispute the clinical value of tracheotomy in croup is a waste of time to no good purpose. Croup or no croup, if there be a positive obstruction to respiration in the larynx it is but according to reason to open a way for sublaryngeal respiration. In the days of more knowledge and less nonsense, tracheotomy will be ranked among the minor surgical operations. [We dispute it.—Ed.]

7. In the dentition it is not the direct or eruptive pressure, but the lateral pressure of all the teeth together, that is most dangerous. It is from this that so many cerebral symptoms appear which can in no way be relieved by incisions in the gums. The only resource against the danger of this transverse pressure is to give the child more nourishment, in the hope that, as the general condition is bettered, the local condition will also be improved.

8. If the incisors of the first dentition are serrated, it is bad, but if those of the second formation are the same, it is worse. It foretells a number of lesions, arising from deficiency of mineral salts in the tissues. There is only one exception, and it is an important one. When the serrated incisors are seen in strong children in whom the fontanelles have closed early, it is a sign of a robust constitution. Instead of a number of small and sharp indentations, there are a few large blunt ones.

9. To regard the eruption of the teeth as the sole factor in the general process known as the first dentition, is to perpetuate a sort of medical synecdoche. Children get their first teeth because they are at the same time getting a second stomach and second intestines.

10. The body of a child possesses such a degree of "acoustic transparency" that, in case of necessity or convenience, auscultation may be practised with the hand, converting it into a telephone, which will reveal as much to the physican as even his ear could do.

11. In practice it is well to distinguish with precision a case in which disease is due to lumbricoids, from one in

which lumbricoids are due to the disease; for, in the former case, anthelmintics are of service, but in the latter they do harm. [Scientific medicine does not require it.—ED.]

12. Since, until the child is able to talk clearly his relations with the physician are purely objective, it is very necessary that we should study as carefully as do the veterinarians, the exact correspondence between the lesions and the expressions of the patient.

13. If you wish to cure rapidly and well, joint-diseases in infants, you must treat them as you would a conflagration,—douches, douches, and more douches, until you have succeeded in extinguishing them.

14. The entire system of the moral relation between children and adults should be changed. To speak to them incorrectly, merely because they cannot pronounce well; to excite their fears and to arouse their weird imaginations, simply because they are easily frightened and impressionable; to stimulate their vanity because they are naturally inclined to be vain,—these and other similar actions are not only wrongs, but absurd.—*Med. Age.*

OBSTETRICS.

CLINICAL CASES.

BY P. BENDER, M. D., Boston, Mass.

The first case I will mention is one of retained placenta of a very unusual kind.

I was called to see the mother of several children who, in the fourth month of pregnancy, was flowing profusely. An examination revealed the embryo in the vagina and the os dilated to the size of a fifty-cent piece, but firm and rigid. By means of conjoined manipulation, with one hand over the abdomen and two finger of the other in the vagina, I succeeded in introducing the index beyond the os and endeavored to scoop the placenta out which was plainly

felt, but failed. I tried next to extract the membranes with the placental forceps—without success, however. When hesitating about using either the tampon, or dilating the os with a tent, the hæmorrhage diminished, and I decided to postpone mechanical interference until more urgent symptoms called for it. Meanwhile I gave her *Pulsatilla*.

The anæmia was so great at one time that the patient would gasp for breath, and sight disappear. Under *China* the patient improved, but subsequently a death in her family called her away from the city. Shortly afterwards, upon her return, four weeks later, she informed me that during her absence she had had three attacks of severe hæmorrhage, but nothing fleshy or solid came away. She now complained of fetid leucorrhœal discharge, stating, however, that she felt well in every other respect. I then urged surgical interference, which she declined, saying, “everything would come right!” Now comes the extraordinary feature of this case, the fetid discharge gradually ceased, her courses returned, and she was soon in the enjoyment of her usual health.

The patient wore napkins constantly throughout the whole time, and at my request she carefully examined all that she passed, and she is positive that nothing larger than a pea was ever discharged.

Desintegration of a portion of the placenta evidently occurred, but what became of the rest? It seems hardly possible that so large a substance as a four months-placenta could have been absorbed, and yet what other conclusion can one come to? I have reason to believe that in the case in question, abortion was procured by mechanical means.

CASE II.—Doubtless some of your readers have met with such cases as the following, which I confess I saw for the first time about twelve years ago, and was considerably puzzled in consequence, never having heard or read of anything similar, although I have since, in the *London Lancet*. I visited one night a patient who informed me that “her time was up and she expected to be confined.” She had suffered

the pains of labor at irregular intervals for upwards of three hours, and upon examination I found the os sufficiently dilated to permit of the passage of the index and middle finger. The other usual accompanying symptoms were also present, but at the expiration of a couple of hours, all pains had ceased, when I decided to leave, giving directions to send for me before morning if my services were needed. To my great astonishment she had no more pains after this until three weeks later, when she was easily and rapidly delivered of a healthy child. My impression is that were physicians oftener called in at an earlier stage, they would find the apparent symptoms of the process of labor some weeks sooner than is generally supposed with most practitioners.

CASE III.—Dr. Playfair's valuable contributions on the method advocated by Dr. Weir Mitchell, of Philadelphia, are additional important evidence in the treatment of old standing cases of hysteria connected with uterine diseases and cases of nervous exhaustion—affections, as a rule, so unsatisfactory to attend. The doctor's system, as many of your readers know, is a combination of seclusion and rest, massage and electricity, diet and regimen, and if the results are such as claimed by Dr. Playfair and the author himself, the profession may well rejoice.

A *propos* of the distinguished Philadelphian physician, he mentions that he has not been able to discover a case of chorea living in the country. Strange enough I had just two such cases from Wellesley, Mass., a healthy country place, near this city. One was a young girl aged eleven, of leucophlegmatic temperament and of excellent physique—more that of a boy than a girl—who without any assignable cause began to have twitchings of the muscles of the face, neck and arms, and to frequently sigh. I administered *Ignatia* high and low, without effect. In addition to the above symptoms I subsequently learned that she had to leave her bed early in the morning to have passages from her bowels, which were yellow in color, pro-

fuse and painless. I gave her *Sulphur*³⁰, which cured her in a fortnight. I omitted mentioning that she had been four months under allopathic treatment, previous to consulting me. The second patient was a pregnant woman, whose most characteristic symptom was involuntary laughter. She was cured in less than a month by *Cicuta v.*

EDITORIAL.

MRS. GRUNDY IN MEDICINE.

To the average practitioner there is nothing more to be dreaded than this ogre—Mrs. Grundy—in medical literature. She not only haunts his every hour, both day and night, with a phantom picture of an infernal demon from the lower regions, ready to prey upon every thought he expresses, on any subject that to him at least, was original, but forces to oblivion many a bright and interesting article that would be found ripe as well as rich in thought. The young practitioner full of energy and ambition, anxious to climb the ladder of fame, hesitates to appear in print without concerning himself with Mrs. Grundy's views of the case; whether the subject or article will be received and endorsed, or rejected, by her, is the all important. The old lady's approval is his ambition; and her disapproval his idea of failure. And yet this hideous monster of the imagination, which lives upon timid, sensitive natures, is to some extent a laudable condition, for if we were all insensible to the opinions of our neighbors, this would indeed prove a queer world. But, on the other hand, do we not often over estimate this ogreish individual and consign to retirement gems of thought, that, if set in proper metal would be an incandescent light to many who are constantly struggling for lumination on subjects of vital importance in medicine. To live continually in an atmosphere of self-consciousness and anxiety, when our own approval is all

that is required; to stand in awe of Mrs. Grundy, when we feel that we have something to report from the clinical field of practice that would be of value to the profession; to make a martyr of ones self because some older practitioner in the guise of this dreaded creature, has passed his adverse opinion upon an opinion, is truly a deplorable condition, that destroys all dignity and freedom of the medical press. It is difficult to say why we yield so unresistingly to Mrs. Grundy, with as good grace as we do, unless we realize she represents the intelligent part of the profession, or because it is a hereditary condition for which we are not responsible, or because it is the fashion; for was there ever a time in the history of medicine, when the old lady was not authority?

NEW PUBLICATIONS.

INSANITY AND ALLIED NEUROSES: PRACTICAL AND CLINICAL. By George H. Savage, M. D.

At first glance this manual rather excites a feeling of repugnance, from the abominable style in which it is bound, a dingy blue cover with blue edged leaves, being in fact about the usual poor style of English medical book publishers. As a prominent alienist remarks, "one feels like taking it up with a pair of tongs in preference to taking it in the hands." But a perusal of its pages well repays one for the outrage upon the eyesight.

Although no precise definition of insanity is given, its relationships, as looked at from two different standpoints—the medical, relating to the physician, and the legal, to society—are plainly pointed out. The chapter on predisposing and exciting causes is very comprehensive, the selections on age, sex and inheritance being of especial interest to the gynæcologist or obstetrician. In reference to classification there are some slight defects; the division into groups being with regard to convenience rather than founded upon any clinical, anatomical, physiological or pathological basis, an error that can scarcely be criticised from the fact, which the author recognizes, that at present an ideal classification upon changes taking place in the nerve centers is impossible.

The space given to general paralysis of the insane constitutes a very commendable feature of the work; the description of the

causes, the stages, the symptoms in detail, the pathology and the differential diagnosis being superior to any published. The photographic illustrations scattered through the work give added force to the descriptions. The final chapters, devoted to the medico-legal aspect of insanity, are necessarily abbreviated, from the fact that to enter upon a discussion of the legal responsibility of the insane would require a treatise on criminal laws and the application of its principles, a subject quite beyond the scope of the work. The treatment of the insane contains many valuable therapeutic suggestions in regard to hot baths, diet, occupation, change of scene and surroundings; but we must disagree as to the direct curative effects of large doses of bromide of potassium, nux vomica, etc., indeed the author says, in his own experience, that he finds it necessary to give hyoscyamin in small doses, as "one-twentieth of a grain would produce alarming symptoms of a collapse."

LONDON, January 1, 1885.

H. H. CRIPPEN, M. D.

PLAIN FACTS FOR OLD AND YOUNG. By J. H. Kellogg, M. D., Battle Creek, Michigan. Published by J. F. Senger, Burlington, Iowa. A striking picture of the author thrown in.

This work is one of those spasmodic efforts that are made every few years to appear philanthropic; to teach the public minds that they are all sinners, or liable to be; a sort of a "go-between" the profession and the laity. This book, not unlike others, that are variously named, teaches the young that they have certain organs that are susceptible of certain conditions, but how sinful it is to test them; on the principle of a mother telling her boy to learn to swim, "but don't you go near the water."

When a medical writer attempts to enlighten the "dear people" about the human body, its peculiarities, diseases and treatment, he invariably makes an ass of himself, and we cannot make an exception in the present instance.

The construction is a rare specimen of eccentricities which are impossible to treat. It seems utterly impossible to regard the author as being seriously inclined and we cannot but look upon its composition as a sort of burlesque on the medical profession. We find much to ridicule, both moral and social. It has the endorsement of the "good doctors" and, as usual, the clergy. It is sold by subscription (book agents), and the only object we are able to detect the author has in view, aside from a desire to air his eccentricities, is money.

PHIL PORTER.

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AND

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EDITED BY

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1885.

COCAINE.

(ERYTHROXYLINE.)

Cocaine Hydrochlorate

(MURIATE OF COCAINE.)

COCAINE ALKALOID,
COCAINE CITRATE,
COCAINE OLEATE,
COCAINE SALICYLATE.

The remarkable discovery announced last October that a solution of muriate of cocaine applied to the conjunctiva of the eye produces complete anæsthesia of that sensitive membrane, has created a demand for the salts of this alkaloid which it has been difficult to supply.

Coca leaves are scarce, and held at a very high figure, and the scarcity is likely to continue for some time. We have, however, been fortunate in securing a supply of leaves of good quality, and are now in position to fill all orders for the alkaloid or its salts.

The extraordinary power of cocaine salts to obtund the sensibility of the delicate membrane of the eye has suggested trial of its powers on other mucous membranes, as those of the throat and respiratory passages, the urethra and genital apparatus, etc., and the results have exceeded the most sanguine expectations. Its almost instantaneous effect in relieving the excruciating pain in otalgia, in some cases of supra-orbital neuralgia—probably of reflex origin—and in toothache, where the nerve is exposed, should secure for it a place in the pocket medicine case of every physician.

Cocaine salts, however, have no appreciable action on the deeper tissues unless given by hypodermic injection, but when so administered are capable of affording great relief in some painful affections. The medical journals are full of accounts of the triumphs of this new local anæsthetic, which is sure to hold a rank hereafter in the materia medica with opium and quinine.

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 2. Illustrations required for original contributions, will be furnished at the expense of the journal.
 3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
 4. Personal controversies, not being of interest to the profession in general, cannot be published. Explanations may be made through the editor. This rule will be strictly adhered to.
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ENDOMETRITIS.

Its Varieties, their Differentiation, and their Appropriate
Treatment.

EDWARD BLAKE, M. D., M. R. C. S., London, England

A convenient division of our subject is into:

Simple endometritis;

Croupous endometritis;

Villous endometritis;

Venereal endometritis.

More or less arbitrary must be all artificial divisions of disease. This is true, partly because of our profound ignorance of the real nature of pathological change during life, partly because hard and fast lines of demarkation between morbid conditions, do not exist outside classic works on this subject.

Nevertheless, if we keep this before our minds we may safely, for convenience sake, throw the commonest types of

departure from health into groups, just as botanists do with the differentiated genera in vegetable life.

The division I have adopted does not pretend to include a tithe of the varied forms of endometritis, but it embraces the constantly recurring species in ordinary practice.

As this is intended to be a therapeutic paper we shall speak of the etiology and of the morbid anatomy in the most cursory manner. A full description of these can be readily found elsewhere.

As for the characteristic generic symptoms of this complaint, they are described with minute accuracy by many distinguished writers, hence much of the misapprehension that exists in the average medical mind for in real life the indications are the reverse of distinctive.

Of course, a certain number of the ordinary and recognized symptoms of pelvic congestion are present. But these are present in varying numbers and to an uncertain degree.

Disturbance, especially of the hæmopiëtic functions, with naturally resulting disorders connected with tissue-innutation are usually present.

The sites selected for the manifestation of these nutritional phenomena being apparently decided by some pre-existing disposition, due either to hereditary tendency or to acquired defect. Hence the great dissimilarity in the outward presentment of cases identical as to internal change. Thus we see endometritis lead in one subject to the development of none but mental symptoms, in another to none but moral signs.

We have seen a well marked systolic bruit developed during endometritis, anæmia not being present, disappear on the removal of the endometric inflammation.

In another group of patients some pure neurosis such as epilepsy, clonus (with that set of symptoms vaguely known as "hysteria," a condition seldom occurring without a definite physical basis) gastralgia, inter-costal neuralgia, motor

palsy and a long list of others, which it is unnecessary to enumerate.

We may admit, then, that it would be ridiculous to attempt to give a complete list of the pathognomonic signs of endometritis, though this has been frequently attempted.

Men who are really familiar with this common cause of dire distress are well aware that scarcely do two sufferers ever appear presenting the same set of symptoms.

Nay, we may go farther and say that patients will come having the same pathological condition, yet it shall be expressed by symptoms which would be superficially described as opposite in character.

For example we usually find increase of the monthly flow in the disease under consideration, but occasionally the menses are scanty, and they may even be suppressed. Some patients have constant leucorrhœal discharge associated with this condition; others come complaining of a dry, and burning state of the genitals.

Experience convinces the careful observer that it is an absolute impossibility, from subjective symptoms or even from external rational signs, to predicate with any approach to certainty, what is the particular deviation from health existing inside the pelvic cavity. *That*, physical diagnosis can alone decide.

That endometritis is difficult of cure most practical men are agreed. Those who are acquainted with the various forms of this complaint really regard it as a serious disease often refractory under the most favorable conditions.

Those who have not acquired any precise knowledge on the subject tell us that they are most successful in curing that which they cannot even diagnose with accuracy and certainty. Our literature contains some really remarkable evidences of the truth of this apparent paradox.

Though much vagueness exists as to the precise amount of hope in the matter of prognosis we may dare to give in a general way in these cases, there does seem to be an ap-

proach to consensus of opinion in the case of at least two of the forms which we usually encounter. For most doctors are in the habit of viewing croupous endometritis (membranous dysmenorrhœa) and also the gonorrhœal variety of this disease, as of considerable obduracy.

It has been claimed by those who set their faces against local medication that even croupous endometritis may be cured by internal remedies alone. A case is recorded in the *Monthly Homœopathic Review*, published in London, England, in 1883, Vol. XXVII, p. 271, as being cured by Cyclamen in the third decimal attenuation. Unfortunately the physician never saw the case for himself, therefore we must receive with reserve this contribution to our stock of medicinal cures, though from one of our best men. We feel sure, too, that this doctor would be the first to allow that the case is an exceptionally fortunate one.

Endometritis Simplex.

Passive congestion of endometrium.

Let us suppose that a fair and full trial has been given to remedies and to rest, and that these have been tried in vain. We next order sustained hot douching, with raised pelvis for from one to four hours a day. A good large kite-tail tampon soaked, if practicable, in a concentrated preparation of the drug which is being administered internally, is applied to the os uteri each night.

This may be done, with the aid of a vulcanite tube, by the patient herself. The remedies from which we have seen the most definite results are Belladonna, Calcarea c., Platina, Cocculus, and Nux vomica. We must add to these the salts of soda and potash which have so striking an elective affinity for the endometrium. Concerning them we have much to learn.

Not long ago we witnessed the cure, in the hands of Dr. Nicholson, of Clifton, England, of an obstinate case of endometritis in an emphysematous lady, who had undergone the operation of ovariectomy. This lady had been

greatly lowered by the chronic ovarian disease at first, and latterly by menorrhagia. She was approaching the menopause. She made a swift and capital recovery under massive doses of Chlorate of Potash. We saw a severe case of endometritis with monthly flooding fall into complete abeyance under *Natrum muriaticum*.

No doubt that the numerous records of cure of profuse menstruation by the Carbonate of lime, scattered through our literature are cases of this kind for had they depended on the presence of polypus or of fibroids, they would scarcely have yielded to medication.

Mustard sitz bath at a temperature of 105° Fahrenheit, raised gradually to 115° Fahrenheit, for ten minutes at bedtime has a valuable derivative effect.

Should the treatment we have sketched above, not succeed in totally removing the disease, or if it had already drifted into the confirmed chronic condition, it is seldom radically cured without local treatment.

Then we may two or three times a week gently and slowly dilate the uterine neck by means of one of the steel two-bladed divergents. Palmer's is a very good dilator, but the instrument makers always construct it in a clumsy way, with the nosepiece too large. The bulbous extremity should not exceed in size a Marion Sims' sound. If it be larger, then in the very cases we need it most, where marked stenosis is present, we are unable to employ this very useful instrument.

It should be remembered that the dilatation not alone allows us to introduce the endometric dressings, but it tends by giving free exit to clots, etc., to remove a fertile cause of the disease.

It also helps to cure sterility and to remove dysmenorrhœa, so that in practising dilatation we meet many of the chief indications of this kind of case.

If done with proper gentleness without undue haste, this is a far safer as well as a much more merciful method

than the tedious tent business, the latter we have seen followed by cellulitis and pelvic abscess, the former never.

Of course some suitable anæsthetic must be given to broken down patients, and to those of an extremely nervous temperament. We now gently introduce on a steel probe a slip of lint dipped in or dotted with Liquor Iodi.

This consists of

Iodine gr.....	20 grs.
Pot. Iod.....	30 grs.
Aque Dist.....	1 oz.

Bad cases require a saturated slip, in mild cases it is sufficient merely to dip the probe in the solution and dot it over the lint.

This gives very little pain, if not applied within forty eight hours of a period. It is removed after four to six hours by means of an attached string.

A dry tampon of absorbent cotton should always be placed over the os, firmly applied to prevent the excess of Iodine travelling back to the vagina and excoriating its walls. The tincture of Iodine gives much more acute suffering than the watery preparation. Soap is the vehicle best tolerated by the endometrium.

Vegetable extracts such as those of Aconite, Belladonna, Thuja, Strychnia, Cocculus, Ergot, etc., may be readily incorporated with castile soap and introduced as "sticks."

It should be remembered that the endometrium absorbs rapidly and freely and that toxic substances should be freely diluted.

We have only twice seen Iodic dermatitis [or pseudo-acne] produced by the treatment, once on the face, and once on the dorsal aspect of the hands. In both cases it soon disappeared without treatment and left no evil effect.

Villous congestion; or *Endometritis Polyposa*.

In this group are included for simplicity's sake a rather large range of conditions. They extend from simple uniform hypertrophy of the villi, making it resemble crimson

velvet pile, to that state wherein the uterus is occupied by solitary or multiple mucous polypi.

This heading does not include sub-mucous fibroids, which may resemble polypi in form and in symptoms, but are so widely different in pathology. They may be distinguished from polypi by their greater density, by being pierced by uterine lacunæ and by their histological qualities.

Neither are "hydatids" to be considered as forming part of this group. They are now known not to be a pathological entity but to belong, like uterine casts to the phenomenon of embryonic development, being merely a drop-sical state of the chorion.

I may here say that vegetations of benign character either on the cervix or inside the uterine cavity never take on a malignant action.

This was thought at one time to be possible. It is now proved that when cancerous changes are found side by side with these vegetations, either the villi appeared at a subsequent stage as a result of the carcinomatous irritation or they fortuitously co-existed as entirely distinct morbid processes, bearing no sort of relation one to the other.

The essential clinical characteristic of cases of villous endometritis is hæmorrhage, it is seldom absent.

These are the cases in which the operation devised by Gaillard Thomas, and christened by him "blunt wire curetting" does such wonders. If the case be uncomplicated, then the beginning and the end of the treatment is the blunt-wire curette.

If practised in appropriate cases and after the method directed by the inventor, the results are undeniably admirable. Sometimes a piece of old adherent chorion left by a former abortion, complicates the case. Then of course the curette treatment is more than ever indicated. If the mass be large and organically adherent Marion Sims' scraper or one of Simon's "spoons" may have to be substituted for the small curette.

If the vegetations be suspected to arise from, or be associated with some venereal affection it would be necessary to super-add the special treatment presently to be described under the heading of venereal endometritis.

In the uncomplicated villous cases, except for the anæmia so frequently present, there is not much medical treatment required. Towards eradicating the polypous diathesis Thuja, Calcareo carbonica and Nitric acid may be thought of

Croupous congestion.

Membranous dysmênorrhœa.

Endometritis crouposa.

Under this head we do not include cases where a complete cast of the uterine cavity is seen. That is so much the reverse of common, that we may never in a life time be called upon to prescribe for a case.

These are now recognized as being very early abortions and therefore they cannot be classed scientifically with endometritis at all. Of course they may be and indeed usually are a *result* of endometritis, but they are not properly to be looked upon as a *form* of it.

Under croupous endometritis are included those cases where lymph laminae are thrown off by women who lead a celibate life as well as by those who are married. Here endometric congestion is associated with the exfoliation, portions of the intra-uterine mucosa having lymph effused into the meshes of its basic connective tissue. We have, with a view to testing the powers of nature, aided by rest and careful symptomatic treatment, kept such patients in bed for periods of three to six months at a time, without a trace of improvement.

We view this disease as one that is definitely outside the pale of mere medicine. There is a better chance of its yielding to systematic hot douching combined with cervical dilatation, with multiple incisions if stenosis be present and the introduction of *Liquor Iodi* on lint, quite up to the fundus for a few hours two or three times a week.

A most guarded prognosis must be given and as no case can be cured under three months, it is better to ask for twelve. The indication of complete cure, in all these cases is that the lint slip, on being removed, is no longer purulent covered with pus.

The remedies are to be sought amongst Aconite, Apis, Cantharis, Cyclamen, Cocculus, Platina, Belladonna, Hamamelis, Sabina, Caulophyllum and Iodide of Arsenic.

Venereal Conjestion.

Endometritis gonorrhœalis.

This disease was long the *bête noire* of gynecologists. It is rash to assert anything in the present limited state of our knowledge, but we may safely say that, until the local treatment was discovered, this disorder was commonly viewed as "past praying for."

Even now whilst it may be fairly erased from the black list of incurable diseases and may be transferred to the curable category, still when it has assumed a virulent type and is complicated with chronic salpingitis and inflammatory changes in the broad ligaments and ovaries, it is a very troublesome disease and it may take years to recover from. It is not infrequently fatal through inducing low types of peritonitis. Happily these bad cases, not unknown amongst *puellæ publicæ*, are seldom encountered in private practice.

The treatment consists mainly in the use of hot carbolized douches 2 to 5 per cent. is strong enough, for one, two or more hours per day, combined with dilatation of the ostia. This procedure should be conducted with more than usual gentleness. Surgical injury in these cases is far more serious than in ordinary non-venereal types.

We have abandoned the use of tents as dilators in a general way, in favor of so-called "forcible dilatation."

We have gradually and slowly come to this practice from the conviction that this instrumental dilatation though perhaps it may look and sound a less safe and a more violent procedure than tenting, is really more merciful

because so much more speedy and it is certainly attended by less risk.

In cases where a gonorrhœal taint is known to exist, and it is frequently difficult to say that it does not, then there is a peculiar proneness for cellulitis to be set up.

The cellulitis may pass into pelvic abscess or into peritonitis of a suppurative type.

The best application to the endometrium in these cases is Iodised phenol, which may be made in the following way:

Iodine, Iodide of Potassium and Dis-	
tilled water.....	āā ʒj.
Absolute phenol.....	ʒj.

This is the strongest preparation that can well be made. It is suitable for the worst cases. Its introduction is followed by pain in some patients but not in all, for a varying period from 10 minutes to the whole time of retention, but no untoward symptoms follow its use.

In cases where the pain cannot be borne, pencils of castile soap containing Iodoform, Extract of Cannabis, Thuja, Copaiba or Santal flava may be employed instead.

The internal remedies are Aconite, Cannabis sativa, Copaiba, Liquor Santal flava, Thuja, Mercurius cor., Kali hydriod. Sulphur, Sulphite of soda and Chlorinated soda.

Patients suffering under the various congestive diseases of the pelvis do better without meat or wine.

The staple diet should be bird, eggs, fish and farinaceæ, with fruit and light salads. Rest is of course essential. Finally there are such good grounds for suspecting, that endometritis is frequently a reflex from the cutaneous surface, that the state of the skin, the kind of bath and the nature of the clothing, should always receive special attention.

APIS.—Great irritation at the neck of the bladder; can scarcely retain the urine a moment, and when passed scalds severely.

LACERATION OF THE CERVIX.*

RICHARD F. SMITH, M. D., London, England.

In diagnosing this condition, it is very necessary to ascertain the previous history and to get a full account of all accompanying conditions both local and constitutional; the date of the last menstruation; the size, shape, consistence, position and other particulars concerning the cervix and uterus are quite indispensable to both diagnosis and prognosis. The most common conditions following the laceration as an effect of the traumatism, are subinvolution, hyperplasia, hypertrophy, cervicitis and endometritis. Subinvolution is an especially certain concomitant, and being due to the laceration, is speedily relieved by operation in long standing cases.

As the laceration is in itself a wound, and sundering of tissues, all the accompanying conditions of a traumatism are liable to follow. The gorging of the blood vessels from this leads to exudation, the cervix is tumid and its capillaries are filled with blood, the villi are prominent and the denuded surface looks granular; so that we have ensuing cervicitis, with exudation leading to the hyperplasia and hypertrophy before mentioned. From eversion of the lips of the lacerated cervix, we must distinguish a patulous os, that may also lead to similar conditions.

The old treatment of the granular condition of a lacerated cervix by caustic is becoming obsolete. It takes time and the cures are not lasting; patients returning again and again with the old condition. In recent cases, rest in bed must be insisted on, and as in any traumatism, this constitutes an important factor of the treatment. In those cases with hyperplasia, there is an added complication in the increased weight causing descent, and often a peculiar form of hypertrophy, the elongation effecting only the cervix.

*Abstract of a series of lectures delivered at the Soho Square Hospital for Women. H. H. Crippen, M. D.

As in a wound of the arm, if the lips of the cut are not brought together, the intervening space is filled by granulation, the attempt of vital force to close up the gap; so it is in the lacerated cervix, the edges are everted and covered with proliferating bloodvessels. This eversion and enlargement of the lips of the cervix may become so great that the labia are as large as the fundus uteri and completely fill the upper portion of the vagina. If these cases are treated by amputation there is danger of cutting into the peritoneum from the rolling of the fundus to one side thus misleading as to the portion of the cervix taken off

Upon the position of the laceration depends, to a great degree the successfulness of Nature's efforts to repair the traumatism. Those lacerations of the anterior and posterior portions of the cervix are more amenable to treatment by simply rest in bed, than a lateral tear, the lips of which tend most to separation.

The symptoms of lacerations depend much upon the progress of the local conditions, among them are irritable bladder, leucorrhoea, inability to stand, dyskinesie and arrest of the involution. If the patient is in an anæmic state phthisis may develop in time, or the site of the laceration may become a nidus for the growth of cancer.

In the treatment of deep fissure with enlargement of the cervix, the use of caustic potash, before referred to, can do but little more than reduce the superabundance of granulations. Various operative methods are in vogue. Professor Martin, of Berlin, amputates the cervix and brings the denuded edges together over the stump; from this he gets good results. Thomas shaves off the superabundant tissues and brings the surfaces together. In treatment by rest much may be accomplished in removing local congestions and hypertrophy. In cases of recent laceration, rest in bed from four to five weeks after confinement will be sufficient; in long standing cases, three to four months may be required.

Some suggestions may be made on the field we have in this condition for clinical observations on the numerous accompanying symptoms. Distant pains are very frequently found and we quite often have the existence of a great variety of neuroses; headache, particularly the pain on the top of the head, that is said to be one of the most constant symptoms of laceration of the cervix; she may complain that her senses are leaving her or that she cannot see. In one case of this kind the patient was sent to an oculist, with the result that no disorder of the eyes could be found; evidently the neurosis was due to cerebral anæmia.

Where the laceration heals by granulation we have the existence of a mass of indurated tissue. This cicatricial tissue is the real cause of the associated disorders of the pelvic organs, by keeping up an increased nutrition with the presence of irritation. A radicle cure is only by removal of this scar tissue by the knife or scissors, not necessarily deeply. The denuded surface is covered with mucous membrane by Emmet's method.

In consideration of laceration of the cervix as a cause of cancer we have Emmet's rather startling statement, that he has never known a woman to have epithelioma of the cervix unless she had some time been pregnant. As for myself, I am quite sure it is one of the causes of epithelioma, but not the only cause. One patient operated upon here recovered well, but subsequently a small nodule appeared on the cervix, which gradually enlarged and she died soon after at the Middlesex hospital. In these cases we have a bad nutrition generally, and from the fact that in the cicatricial tissue there are no lymphatics or absorbents, we get a change from the deposit of epithelial elements.

In performing the operation there are some points to be guarded. Rest must be insisted on for a few days prior to the operation, and the time for operating should be selected for a few days after a monthly period. If cellulitis co-exist it is advisable to wait until this subsides. Finally

the patient in being prepared for the operation should be given a hot hip bath. The cervix often appears larger than it really is from the invagination that may be present; this may be corrected by placing the patient on her hands and knees for a few moments before the operation. If versions or flexions exist they may be corrected at the time of operation but no pessary should be introduced.

The cases treated here have ranged from 19 to 59 years of age. Several cases have been operated on with cellulitis and there have been a few where cellulitis has set in afterwards. All of these have made good recoveries except one that is still in a chronic state. Some few have had complications following treatment. One case had phlebitis of the left leg; one, paraplegia for six months; both made good recoveries. Two cases have had children since the operation. The report received from one of these cases states that the labor was easy and natural. In both cases only a very small portion of the scar of the operation can be seen. One case, 45 years old, suffering from retroflexion, a large induration and unable to walk for two years, was perfectly restored to health by the operation, and she recovered perfect health. Indeed, if there be, in any old cases a history of predisposition to cancer in the family, it becomes a duty to operate as soon as possible.

These few remarks will, it is hoped, lead my hearers to a further consideration of the subject, with the result that our American brethren will no longer be able to say that we on this side of the Atlantic, have allowed the operation for relief of laceration of the cervix to fall into disrepute.

LAC CAN.—Burning pain in uterine region and particularly in region of left ovary, extending downward into the thigh.—Laura Morgan, M. D. Severe pain uterine region, with profuse discharge of yellow, brown and bloody leucorrhœa, two weeks after menstruation (Bov); intense pain and enlargement of left ovary (cured).

A CASE OF TOUGH MEMBRANE.

BY H. C. KASSELMAN, M. D., MIDWAY, KY.

Last November I was called to attend a Mrs. C.,—age 26, mother of two children. The history of her previous confinements showed that she had not suffered any ill effect except slow convalescence. On examination per vagina, diagnosed head in the upper strait in the first position, L. O. A. (left occipito anterior) but I noticed there was a peculiar leathery sensation imparted to my finger as if something was between it and the head. On questioning the woman I soon learned that “the waters had not broken” or if they had she was not aware of it. The os was dilating nicely and the pains were progressing as well as could be wished for. On further questioning I learned she had been in the habit of running the sewing machine more or less, and continued the work up to the day of her confinement. After a short time I again examined the patient and found the os fully dilated and head engaged. The pains were now strong but the head failed to descend. Waiting a short time I again examined her and found the membrane intact and drawn tightly over the head of the child; the *liquor amnii* having receded. I made an attempt to rupture the membrane with my finger nail, but could not. I then used my pocket probe with no better success. Finally after waiting some time and noticing the pains becoming weaker and the patient exhausted, I took my pocket scissors and carried the blades on my fingers up to the membrane, and then cut the dense tissue. Following this treatment came a severe pain, which delivered the child. The woman made a rapid recovery and all are doing well, especially the boy, who may be President of the United States some day unless canal boats and such things are abandoned.

One word in regard to the use of the scissors. Some-

will doubtless say that I used the scissors without any authority, as the books are silent in regard to their use, but I think it is because authors are afraid of their abuse rather than their use.

A few days before I was called to the above case I read, in a medical journal, an article on this very subject, which spoke very highly of the practice and said he used them in about ten per cent. of his labor cases. Had I not read the article, (a strong plea for the medical journal as a class) in question I would doubtless have been obliged to call in some older head, (Dr. K. graduated two years ago) but receiving courage from the article I was fortified by it, and then succeeded in a case in which I would have otherwise failed.

If the practitioners would report more of their cases, we younger physicians would be better fitted for just such cases and often succeed in handling them alone, and save us, not only from mortification, but give us better professional standing.

PUERPERAL FEVER.*

GEORGE ROYAL, M. D., Des Moines, Ia.

When the above subject was suggested for our discussion this evening, I was in hopes the chairman would choose some other member of this society to prepare the paper; some one, who, from experience could present the subject consisely and clearly.

On looking over the literature upon this subject, I find that, until within the past few years, puerperal septicæmia, puerperal pyæmia, puerperal phlebetis, puerperal peritonitis, and puerperal metritis were spoken of by most writers, as one and the same disease, and that puerperal fever was the synonym of one or all of them.

All attempts at differentiation had only resulted in

*Read before the Po'k County Homœopathic Medical Society.

greater confusion. Within the past few years, however, much light has been given us, so that, at the present time, our best physicians recognize these diseases as distinct in etiology and pathology producing different symptoms, and therefore calling for a different therapia, while the term puerperal fever has been discarded by them. We shall only have time, in this paper, to speak of one of these diseases; puerperal septicæmia, leaving the others for some future meeting.

DEFINITION.

By puerperal septicæmia we understand a morbid condition of the blood caused by some septic or putrid matter, other than pus, introduced into the system, (by inhalation or by contact with an abraded surface) during the puerperal state. This condition being characterized by a very rapid rise of the temperature to from 102° to 107° with a pulse rate of from 120 to 150.

ÆTIOLOGY.

The cause of this disease has already been stated in the definition, viz: The introduction of some septic or putrid matter into the system. Without entering into a lengthy discussion, (which may be found in any extended work on this subject) to prove the statement, we will say the source of this poisonous matter may be any of the following:

First. The patient herself; a fragment of the placenta; a coagulum of blood; a fiber of tissue may decompose in or about the uterus or vagina, and become the torch that kindles the conflagration.

Second. From one infected patient to another; by soiled fingers of the attending physician.

Third. The dissecting room and post mortems.

Fourth. Patients suffering from erysipelas, scarlet fever or diphtheria.

Fifth. Certain atmospheric conditions.

When from any of the four above mentioned causes, or

any other, a case originates, there seems to exist at times certain atmospheric conditions which take up the germs and spread them so that nearly every parturient woman contracts the disease.

This, only, will account for epidemics such as occurred in Leeds in 1809-12, in Edinburgh in 1825 and in London in 1827-28.

The abrasion of the mucous surfaces caused by the act of parturition is always a predisposing cause to this disease. Putrid or septic matter conveyed from any of the above sources, either directly by the attendants themselves, or by any other means, may be the exciting cause. Besides this there is a morbid condition of the system that so predisposes the patient that mere inhalation of the poison will excite the disease.

Concerning the manner in which the seed may be conveyed to the already prepared soil, little need be said. It is evident it may be carried by the attendants under the finger nails, in the clothing, the hair, the beard or even the breath itself.

PATHOLOGY.

If the poison has entered by an abraded surface about the vulva, the point will look red, sometimes purple resembling malignant erysipelas. The lymphatic vessels may be traced from gland to gland by their red inflamed condition. The lymphatic glands themselves are somewhat swollen, tender, and in protracted cases those of the neck axilla and groins are found in a suppurated condition. The greatest change however is in the blood. Its composition is altered. It becomes defibrinated, much darker in color, and seems to contain more than the usual amount of serum. Dr. F. Smith states that: "In the most rapidly fatal cases nothing has been met with beyond non-coagulability, thinness and blackness of the blood. The blood in these cases resembling that of persons killed by lightning or hydrocyanic acid." In speaking of septic lymphangitis, Holmes

says: "It is that form of lymphangitis produced by snake bites and dissecting wounds and which is so freely associated with puerperal inflammation."

DIAGNOSIS.

That a correct diagnosis should be made at once is of the greatest importance. For not only will this enable the physician to give his patient proper attention, but will prevent his carrying the disease to others. Occurring as it does immediately after parturition the only disease with which it is liable to be confounded is pyæmia.

The best differentiation I can give between these two diseases is that made by my respected instructor in surgery, Prof. Helmuth. I will only add one point, viz., the length of time after delivery before the attack. This will make the differentiation as follows:

SEPTICÆMIA.	PYÆMIA.
The attack is usually before the fifth or seventh day after delivery.	The attack is usually after the fifth or seventh day.
Caused by poison absorbed by direct contact.	Caused by pus.
Virus carried by the lymphatics.	Carried by the veins.
A single chill.	Many chills.
No regularity of recurrence of fever.	Paroxysms of chills, followed by fever, sweat with regular intermissions.
Temp. 104° to 107°.	Temp. 102° to 103½°.
Paleness of or flushed face.	Jaundiced hue with yellowness of the conjunctiva.
Rather offensive breath.	Peculiar sweetish odor of breath (like new hay).
Rapid progress.	Slower progress.
Delirium and exhaustion.	Less delirium and more prostration.
Pains not general.	Severe and fugitive pains in legs, abdomen and back with swollen joints.
No infarctions.	Infarction of viscera, lungs, liver, spleen and kidneys.
A single abscess or perhaps two, generally superficial.	Multiple abscesses in internal organs.

COURSE AND PROGNOSIS.

This disease runs a very rapid course, especially in epidemics. It terminates fatally or spends its force in from a few hours to a few days. Convalescence, however, is pro-

tracted and recovery slow. The prognosis is always grave. Figures show that the rate of mortality varies in different epidemics; the per cent. being fifteen in the mildest, while others are so severe that only now and then a patient recovers.

SYMPTOMS.

There may be pains about the point of absorption or rheumatoid pains in different parts of the body for a few hours before a severe chill. Or the first symptom may be the chill which is followed at once by a very rapid rise of temperature which, in a few hours, will reach from 102° to 105° . The pulse beat is increased at the same time to from 120 to 160 per minute. It may be full and bounding, or small and wiry. There is mental restlessness and anxiety; usually delirium, but at first the patient can be recalled to her senses. The eyes are bright and sparkling. The mouth dry, breath fetid, tongue coated, taste putrid. The lymphatic glands and vessels become inflamed, red, tender, and sometimes the glands suppurate.

The pains in the different parts of the body continue. There is rapid and profound prostration of the nervous system. Although the temperature is very high, the body is usually bathed in an offensive perspiration. In most cases there is a slimy fetid diarrhoea. To the above may be added the symptoms of peritonitis, metritis, or other puerperal diseases that may enter as a complication.

TREATMENT.

The object of the treatment should be fourfold: Preventive, Antidotal, Medicinal, Hygienic.

First and most important of all is prevention. Every physician who is treating any of the diseases mentioned as sources from which the poison may be carried should attend a lying-in patient, only after a most thorough disinfection of the hands, hair, beard and clothing. I believe physicians are not careful enough in instructing the nurse to

cleanse the vulva and vagina with tepid water medicated with carbolic acid, arnica or calendula. Aside from affording the patient a great deal of comfort, these injections, properly used, keep the parts clean and help heal the abraded surfaces. My preference is for calendula. As soon as the labor is completed and the mother has rested a few moments, all articles of clothing that have been soiled, should be removed, the blood should be washed from the person, and everything left dry and clean. The second point in the treatment is to antidote the poison as soon as its presence is ascertained. For this purpose use carbolic acid. On this point I will again quote Prof. Helmuth: "As I believe in the antidotal power of *quinine* in certain, severe and pernicious intermittent fevers, as I believe in the antidotal effects of mercury and potash in the treatment of syphilitic fever, in the same degree do I believe in the antidotal power of Phenic acid in the treatment of septicæmia and pyæmia." He (Helmuth) recommends the use of *Déclat's Nacent Phenic Acid*, hyperdermically 40 to 80 minims every night and morning. Some writers advise the injection of this acid into the cavity of the uterus. There is but one condition that permits the use of injections into the uterus in the puerperal state, and that is when there is a sanious, fetid discharge from that organ showing that something has been retained and is decomposing. For this condition injections should be used for the purpose of washing out the putrid matter. Injections into the uterus, during this state, are dangerous, and under any other conditions are contra indicated. These remarks will apply to all the puerperal diseases, mentioned at the beginning of this paper. The third point in the treatment will be the selection of the proper remedy. One of the following will usually cover the symptoms. *Rhus*, *Acon.*, *Lach.*, *Crot.*, *Ars.*, *Verat. vir.* *Mur. ac.* and *China*.

Rhus.—Has a low delirium, great restlessness, a fiery or dark red face, dry mouth with great thirst and putrid

breath, a yellowish-brown, bloody, cadaverous smelling diarrhoea, rheumatic pains in the joints and different parts of the body, accelerated pulse, chills, high fever and at the same time a musty putrid sweat. *Rhus* should be used when we expect trouble, before the disease is developed.

Aconite.—Then comes Aconite with a prolonged and violent chill immediately followed by a quick, hard, full bounding pulse; very high temperature; skin hot, pungent and dry. Never any perspiration. Intense thirst. Brilliant glassy eyes and marked restlessness, with anxiety. It will be useful mostly in the first stage.

Lachesis.—For those who prescribe on pathological grounds the snake poisons must have a peculiar charm in this disease. In fact no one who has ever read Carroll Dunham's lecture on Lachesis, or listened to what it did for him when suffering from septicæmia, can doubt the virtue of Lachesis in this disease. And especially will it be useful if peritonitis be present as a complication.

We have the mutturing delirium, great loquacity, bloated red face, trembling dry red tongue, bad odor from the mouth, insatiable thirst, painful distension of the abdomen which is hot and sensitive, so sensitive that even the least touch of the clothing produces severe pain, and the slightest pressure is unendurable. The stools are thin and slimy, weak accelerated pulse, internal sensation of heat, profuse sweat. Difficulty in swallowing warm drinks. The patient always dreads to go to sleep, because she knows that all the symptoms will be aggravated by the sleep. The power of this poison to disorganize the blood is well known to every follower of Hahnemann.

Crotalis.—Has most of the symptoms of Lachesis. Its action on the blood is even more profound. It so liquifies the blood that it exudes through the capillaries, causing discoloration of the skin, and a tendency to hæmorrhage from every orifice of the body. The delirium is mostly at

night. The loquacity of Lachesis is wanting, and the Cro-talis patient does not sleep herself into an aggravation.

Arsenic.—With Arsenic we seldom have delirium, but great fear and restlessness, with the aggravation after mid-night. There is a haggard, distressed, hippocratic expression of the face; an unpleasant, putrid taste; tongue coated white on the edges with a red streak down the center; dryness of the mouth; intense thirst for cold water which is vomited immediately after drinking; involuntary stools of green slimy mucus; abdomen distended and painful; pulse rapid, weak and thread-like; cold, clammy offensive sweat, most profuse on going to sleep. Great prostration. This remedy will be found most useful when the poison has spent its force, and it is doubtful whether the disease will terminate in death or recovery.

Veratrum vir.—Has a mental confusion or stupefaction. The face has a besotted expression, almost purple from congestion. The pulse is accelerated, strong, full and tense, with throbbing of the carotids; in fact intense congestion of the whole arterial system. Temperature from 105° to 107°. Under these conditions, Veratrum will control the heart's action, and restore the equilibrium of the circulation, thereby preventing convulsions or coma. Veratrum, like Aconite, will be found most useful in the first stage.

Muriatic acid.—Will be found useful after Rhus when the restlessness has given place to prostration, and we have drowsiness with continual moaning during sleep instead of sleeplessness, with low, muttering delirium. The pulse is slow and weak. The stomach is also weak and there is difficulty in retaining and assimilating food. The diarrhoea continues. There are pains in the limbs, and the joints feel bruised. This remedy like Arsenic is most useful in the first stage of convalescence.

China.—Will be most frequently called for later on in the stage of convalescence.

After Arsenic or Muriatic acid have lost their effects there may still exist a painless diarrhoea, more or less prostration, weakened digestive powers, frontal headache, want of appetite, an occasional recurrence of the fever and night sweats. Symptoms showing that the waste of protoplasm has not been entirely controlled. For this special purpose we have no better remedy than China.

In addition to the remedies, the indications for which have been given above, may be mentioned Carbo veg., Bryonia, Belladonna, Sramonium and Phosphorus.

Alcohol also has its advocates in this as in all other diseases. Many physicians use it as an antidote, some stating that a definite amount should be given daily, while others insist that it should be pushed till its toxic effects are produced, which amount, in some cases, is simply enormous. The use of alcohol in septicæmia, and of opium in peritonitis is an example showing the amount of poison the human system will tolerate, while some other poison is at work upon it at the same time, But I believe we have homœopathic remedies that will cure peritonitis more speedily and safely than massive doses of opium, and I also believe that phenic acid, as an antidote, and the administration of the proper remedy to be a much safer and better treatment for septicæmia than the alcohol.

Alcohol, as given by other physicians merely as a stimulant, is of very questionable service in this disease. I am convinced it does more harm than good.

HYGIENIC TREATMENT.

The patient should be placed in a darkened room and kept as quiet as possible. All but the attendants should be excluded from the room. Cool drinks should be freely allowed. Baths of warm water should be frequently given. If the patient be not delirious she should be fed milk, milk and eggs, strong beef tea and broths, at short and regular intervals. If delirious so that she will not take the food

enemas of milk and eggs, and beef tea should be given. The quantity should be regulated by the patient's capacity to assimilate or absorb.

NEUROSTHENIA—OOPHORECTOMY.

(Report of Clinical Cases Contained).

PHIL PORTER, M. D., Detroit.

CASE III.—Mrs. B—, æt. 27, German. Patient of Dr. O. Lang, of this city, a well-marked case of neurosthenia. Had one child at full term but has been unable to carry any more through to complete gestation, owing to her suffering which was truly pitiable. Her pain was principally located in the abdominal cavity, shifting from one place to another, but always severe. She could carry her children to the seventh month, but no longer. The temperature would rise to 102–103° with the pulse at 120, which could not be lowered until the uterus had been relieved of its contents. With the birth of her first child there was a laceration of the cervix which nature had made a partial attempt to unite but included considerable cicatricial tissue, which, I thought, might account for some of her reflex disturbances; but an operation which was a success, failed to bring any relief. There had always been a tenderness over both ovarian regions, and as a forlorn hope, I suggested oöphorectomy, explaining the condition it would leave the patient in if she recovered from the operation. Her years of suffering had prepared her for anything that encouraged relief, and she not only acquiesced, but could hardly wait for the day set for the operation. Before and during the operation everything was done to protect the patient against peritonitis or any other complication that might arise. Previous to the operation she had also been a sufferer from a spasmodic urethral stricture for nearly three months. As soon as the

patient was under the influence of the anæsthetic I introduced Wincket's graduated urethral dilators, commencing with No. 2 and finishing with No. 6, which I left in the urethra until after the operation. This mechanical treatment of the urethra had the desired effect over the stricture, as she never was troubled with the stricture again. On opening the abdomen, both ovaries with the fallopian tubes were found very much hypertrophied and on more minute examination I found several small tumors, about the size of kernels of wheat composed of nerve tissue—small neuromas—which readily accounted for the severe lancinating pains she complained of. I desire to state, in relation to the therapeutical treatment of this patient, that everything that was indicated, during the two or three years she was under homœopathic care, she had in all attenuations. Dr. H. C. Allen saw her several times and agreed on an operation. I make this full explanation because I always desire some extenuating circumstances which justifies an oophorectomy. I am not personally in love with the operation, because it smacks of a make-shift, as it were. This patient's recovery was complete and satisfactory, and the result demonstrates the justification of the operation. She, of course, is relieved of the excruciating pain of the *ovarian dysmenorrhœa* every month and most of the reflex pains are also relieved.

CASE IV.—Mrs. W---, an American, large, fleshy person. Had enjoyed good health since the climacteric period until about one year ago when she commenced having pain in the left ovarian region, which was associated with all the distress of neurosthenia. The paroxysms increased with time until she was referred to me, and at that stage of the disease her suffering was constant except when under the influence of an anodyne, either Svapnia or Morphine. The pain was lancinating in character and described by the patient as radiating from the ovary. There was also a yellow, creamy, leucorrhœa, which excoriated the parts.

When pain was very severe she complained of a bearing down sensation. On physical examination I found a hard tumor of the left ovary, or at least in that locality, which, on manipulation, caused pain. There was some abdominal effusion. Two weeks later I operated and removed a sarcomatous growth of the left ovary. It is quite unusual for tumors of this character to produce any great amount of disturbance and I cannot now understand why this growth was an exception. The right ovary presented the usual appearance of an atrophied ovary and was not disturbed. The patient walked to church, a distance of six blocks, four weeks after the operation and has never complained of pain. Conium was prescribed by her attending physician, and from all her symptoms both sympathetically and pathologically, should have afforded some relief. I was disappointed in its action, after we had made a comparison and found this was the remedy.

CASE V.—Mrs. L—, æt. 26, married three years, nervo-sanguine temperament, American, resident of the city of New York. Had never menstruated normally since puberty, each period ushered in with severe ovarian pain and twelve to twenty-four hours later a slight discharge from the vagina would follow, lasting but a short time—four to six hours. From her description I would judge it was principally mucus mixed with some blood. She was also suffering from neurosthenia and although, on examination, I found the uterus undeveloped, with no trace of a right ovary, she was afflicted with nymphomania. Last November I operated on her for removal of the left ovary and found that organ very much enlarged and congested. There was but a rudimentary fallopian tube on this side while on the right, no ovary or tube could be detected, although there was a slight thickening of one portion of the broad ligament. The date following the operation that would have been her proper menstrual nixus, she experienced some discomfort, especially from vesicle irritation, which was

readily controlled by *Bell*.³⁰ Her relief has been complete except from the nymphomania, which she claims is gradually but surely coming under control of her mind. She writes: "I can observe a steady and positive improvement over my sexual feelings."

(Continued.)

COMPARISON OF ELECTRIC CURRENTS.

Editor Medical Advance:

THE ADVANCE of February contains an article headed "Electricity," in which a certain case is reported, with reference also to others, and the conclusion is drawn that "these cases show the superiority of the galvanic to the faradic current." The editor concludes, and says that "in treating the diseases of women" he "is decidedly in favor of the galvanic current."

This to me seems to lack discrimination and sufficient investigation. Whether one current is better than the other must depend on what you wish to do with it, for there is an important difference between them. The galvanic is more especially a disorganizer, and this comes from the greater resistance it meets in even the best conducting substances. The faradic will pass readily and harmlessly through a very long and very fine copper wire, through which a galvanic of the same gravity cannot be driven more than a few inches and this portion will be bent and destroyed. And yet the faradic is far more intense than the other. It will excite contraction in muscles much more readily. That this arises from rousing vitality in the system is evident from the fact that dead muscles cannot be made to contract at all. The faradic therefore is the best current for calling the natural powers into action; for throwing off disease in this way; for inducing absorption of exuded matters; for dispersing morbid growths and swellings as far as the vital forces are able to go. And this covers more cases even of a surgical nature, than is commonly supposed. I speak

from an experience of seven years, during which I have made electric treatment a sort of specialty.

But if you wish to disorganize any part, if you would destroy something, the galvanic battery is doubtless the best. It would be very likely to destroy the foetus in that case of "extra uterine pregnancy," or any other pregnancy, "after having employed the faradic" in vain or with partial success. But is there no danger, in such cases, of destroying the mother also? If a few more cells had been added to the "thirty" in the quoted case, or if they had been stronger, where might she have been? Was not the current passed through her? I once constructed five cells on the *grenet* plan, directed the current from these through a Ruhmkorf coil, and it was instantly on fire—blazed up fiercely. What if this current had gone through a woman for the purpose of killing a foetus inside, or for any other purpose? The thirty cells used in the above case were of course very weak, but if so many cells are recommended without qualification, who knows but that somebody may be killed pretty soon?

Further: It is said, in the article under consideration, that "by a rough comparison * * * a twenty-cell galvanic current is about equal to a full current of a one-cell Kidder faradic battery in the treatment of this condition." It is further stated "that the faradic current had a very decided effect; growth was checked," etc. If such was the effect of a one-cell faradic current, which did as much as a "moderate galvanic current (of twenty cells)" which also "failed to destroy life," might not a faradic current of two cells have done as much as the other current of thirty cells finally accomplished? And might not its less disorganizing nature have been softer for the mother?

The scientific facts pertaining to electricity do not seem to be understood in their bearing upon medical treatment. There must be an overhauling of the whole matter. There is a great future before it.

LEWIS BARNES, M. D.

CRYING, AS A THERAPEUTIC SYMPTOM.

Constant crying, with anxious looks and great uneasiness; in chest affections; *Aconite*.

Whines, frets, constantly gnawing at fingers or something else during dentition; *Aconite*.

Cries pitifully when refused the least thing; *Chamomilla*.

Suddenly and ceasing suddenly, appearing as if nothing had been the matter; *Belladonna*.

During and after nursing, or as soon as the child begins to take food; *Arsenicum*.

Cries horribly, turns blue all over; seems full of incarcerated flatus; *Senna*.

Cries and screams before passing water, relieved immediately after; *Lycopodium*.

Crying with colic, relieved by carrying it with belly resting on shoulders of nurse or pressing firmly against it; *Stannum*: better when pressing hand on belly; *Colocynth*.

When crying, without being angry, breathing ceases; *Cuprum*.

Cries every time it coughs or even before, as though dreading cough; *Arnica*.

Cries terribly if you take the child by the hand to lead it; *Cina*.

QUIZ-COMPENDS. A compend of obstetrics, by Henry G. Landis, A. M., M. D., Professor of Obstetrics and Diseases of Women in Starling Medical College. P. Blakiston, Son & Co., Philadelphia, publishers. p. 115. Price, \$1.00.

It takes but a glance to recognize the value of a work of this character, not only, as the author states, "to the student," but to every practitioner in our school. It is seldom we are called upon to review a medical work that gives us so much pleasure to endorse and recommend, as the above "COMPEND." It is a good "companion book" for the physician, when waiting at the bed side of a labor case. Can be carried in any coat pocket. The cost of the work does not by any means, indicate its real worth.

PHIL PORTER.

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COCAINE.

(ERYTHROXYLINE.)

Cocaine Hydrochlorate

(MURIATE OF COCAINE.)

COCAINE ALKALOID,
COCAINE CITRATE,
COCAINE OLEATE,
COCAINE SALICYLATE.

The remarkable discovery announced last October that a solution of muriate of cocaine applied to the conjunctiva of the eye produces complete anæsthesia of that sensitive membrane, has created a demand for the salts of this alkaloid which it has been difficult to supply.

Coca leaves are scarce, and held at a very high figure, and the scarcity is likely to continue for some time. We have, however, been fortunate in securing a supply of leaves of good quality, and are now in position to fill all orders for the alkaloid or its salts.

The extraordinary power of cocaine salts to obtund the sensibility of the delicate membrane of the eye has suggested trial of its powers on other mucous membranes, as those of the throat and respiratory passages, the urethra and genital apparatus, etc., and the results have exceeded the most sanguine expectations. Its almost instantaneous effect in relieving the excruciating pain in otalgia, in some cases of supra-orbital neuralgia—probably of reflex origin—and in toothache, where the nerve is exposed, should secure for it a place in the pocket medicine case of every physician.

Cocaine salts, however, have no appreciable action on the deeper tissues unless given by hypodermic injection, but when so administered are capable of affording great relief in some painful affections. The medical journals are full of accounts of the triumphs of this new local anæsthetic, which is sure to hold a rank hereafter in the materia medica with opium and quinine.

We offer the following preparations of cocaine:

COCAINE ALKALOID.

In 1 gramme vials, per gramme...\$5.00
In 5 and 10 grain vials, per grain.. .35

COCAINE CITRATE.

In 1 gramme vials, per gramme... 5.00
In 5 and 10 grain vials, per grain.. .35

COCAINE MURIATE, salt, amorphous.

In 1 gramme vials, per gramme.. 5.00
In 5 and 10 grain vials, per grain.. .35

COCAINE MURIATE, 2% solution.

In ounce vials, per ounce..... 5.00

COCAINE MURIATE, 4% solution.

In ½ ounce vials, per ounce.....\$6.25

COCAINE OLEATE, containing 5% of the alkaloid.

In ½ ounce vials, per ounce..... 9.00

COCAINE SALICYLATE.

In 1 gramme vials, per gramme... 5.00
In 5 and 10 grain vials, per grain.. .35

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—OF—

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LAPAROTOMY vs. EMBRYOTOMY.

BY MRS. M. B. PEARMAN, M. D., ST. LOUIS, MO.

Our best authorities only recommend operation in those cases where we have extra-uterine pregnancy and only used then with the expectation of saving both mother and child, in rare cases, where the location of the mis-placed foetus is from an early day in the abdominal cavity, and so placed as to go to full term, or nearly so, without rupture or causing dangerous disturbance to surrounding or neighboring organs.

The teachings are of such a nature, that if followed the accoucheur will not be thinking of the possibility of laparotomy in any except a case as above described, hence, even in extra uterine pregnancy, with delayed labor, the symptoms of pain and apparent contractions of the uterus being somewhat central, will not arouse the accoucheur to the facts, even in these rare cases ; and they are generally

allowed to pass beyond the limits of safety, before the operation is thought of.

Two things render laparotomy a much less dreaded operation than in former times, to wit : Discovery of the use of antiseptics and the familiarity of acquaintance with the different tissues and what can be done with them.

The ever increasing success of, and marvelous results obtained by ovariectomy, an operation just as dangerous, *per se*, as laparo-elytrotomy or laparo-hysterotomy would lead the obstetrician to believe that it is possible to perfect the methods and subsequent treatment of laparotomy so that it will be less dangerous to mothers even than embryotomy.

The murdering of the fœtus does not guarantee the life of the mother, though it is performed solely in her interest; for it offers no hope of the promised life to the unborn, but pleads professional justification for its butchery.

We also find some of our leading obstetricians advocating and performing abortion in cases of deformed and contracted pelvis, which ends all hope of a viable fœtus.

True, embryotomy is among the most ancient obstetric operations, and all text books are full of indications for its performance ; leading obstetricians are employing it daily; yet all this argues nothing in a scientific aspect against any other method or procedure which has for its purpose the saving of two lives--mother and child.

The fœtus is the creation of a new being, and on the broad grounds of humanity, a life is a life ; of course, if it were a question of no alternative, simply destroy one, that the other might live, then we would all advocate embryotomy; but not so, for we have in some one of the forms of laparotomy our relief.

Accident and the surgeon's knife have been able to tell us that these certain tissues can be handled, if not with as much safety as those of more common operations, certainly with much less dread than had before attached to them.

This fear, dread and awe of opening the abdomen, especially cutting the peritoneum, seems likely ere long to pass away, and that it may become one of our recognized operations in the lying-in room in cases of dernier resort, under circumstances of which the following may be a fair general statement, from which causes are found in our text books cases which recommend as a last resort, embryotomy. A large majority of these cases are caused by conditions which render the delivery of a live child impossible, and should certainly be found out by the attending physician before nature in her faithful and often terrible efforts to overcome whatever is interfering with the fulfilment of nature's maternal effort has exhausted the mother and destroyed the child, or so impacted the presenting part, as to render any solution but embryotomy impossible. With embryotomy, the child of course is lost, and the danger of doing harm to the mother in addition to the great exhaustion which already exists, is as great I believe as in laparotomy, taking into consideration the possibility of deciding the necessity for laparotomy before the patient is so exhausted and the great advancement there has been made in knowledge how to handle these cases, when it is necessary to open the abdomen. It is not always in these cases being necessary to cut the peritoneum, but even when thought best to cut right through it, as well as through the uterus itself (laparo-hysterotomy) it is undoubtedly better even then, in many cases, than embryotomy; but when performed as revived by Thomas (laparo-elytrotomy) the peritoneum not being cut, but simply held up out of way, and child extracted through incision in vagina, it should unquestionably be our procedure.

I will be more specific and mention a few of the conditions when laparotomy in one form or another seems to me preferable to embryotomy, viz.: Where there is transverse presentation and podalic version is found to be impracticable; in such cases the cutting to pieces of the child

involves great danger to the mother, probably accurate figures will show as great a mortality to mothers from this operation as from laparotomy with the present improved method of operating. Another place when laparotomy seems especially adapted is, when there is deformed or justo-minor pelvis which is evidenced by the head not entering the brim, hence making the embryotomy if not impossible, exceedingly difficult, and in proportion to the difficulty dangerous to the mother. In both of above conditions, there is little doubt but that laparotomy as performed at the present day will give us as a result, at the end of twenty days, as many live mothers and save nine out of ten children otherwise sacrificed, possibly even a larger per cent of children saved. Other conditions where embryotomy has been in the habit of being used, will undoubtedly suggest themselves to many, and will undoubtedly in time, be included in the not only possible, but advisable methods of terminating complications of the lying-in room, especially when occurring at or near the brim.

Through all the time since Hippocrates, craniotomy has been used as a dernier resort, and during all this time, we everywhere see evidences of the better minds of every period, from his time to the present, casting about for some way to save some of the children without too great a sacrifice to the mothers. With the advanced knowledge of the present day upon the subject of opening the abdomen by one of the methods of laparotomy, laparo-elytrotomy, laparo-hysterotomy, either of which may undoubtedly be used, especially the former, with as much safety to the mothers, and if not delayed too long a larger per cent of children (which by embryotomy are all lost) may be saved.

We know that in every case of labor two lives are endangered; fortunately with little or no assistance, nature is equal to bringing both safely through in all but a compa-

ratively few, and it is still more fortunate, that a majority of the exceptional cases needing what we term "active interference," may be brought to a favorable termination by conservative means, and the day is not far off when the radical means to be considered will be those which will consider the child a human being and worth saving instead of deliberately butchering it.

Two lives are always at stake. In 100 cases with embryotomy the 100 children are ruthlessly destroyed, and not less than 20 per cent of mothers, thus but 80 lives out of 200 are saved; while with the limited experience of laparotomy already had, we have nearly as large a per cent. (74), of mothers saved, and 80 per cent. of children; that is to say, by laparotomy in its various forms we have as a result 154 lives out of a possible 200 as against but 80 out of 200 by embryotomy.

By the Porro-cæsarían operation (laparo-hysterotomy) we have 73 per cent of mothers and all the children saved, and no liability to repetition.

We have cases that have been operated upon by laparotomy several times yet live to a good old age, and enjoy their children and children's children.

A case well known to recent history is that of Mrs. Reybold, upon whom no less a celebrated man than Dr. Meigs twice performed craniotomy, and refusing a third time to commit foeticide, she was operated upon by Cæsarían section twice, the result being a living child each time, and she still lives to enjoy not only her two children, but six grand children. The moral side of this question might be dwelt upon almost without limit, but the figures and facts give us all the argument we need. Facts are stubborn things. Right will prevail, and we shall yet see as a popular method and safe egress from dangerous complications in our obstetrical practices, the operation of delivery through the abdomen.

Each time after I have performed cephalotripsy, my

sympathy with the disappointed, childless mother, has been so great, as to fill me with repugnance at this horrible, one-sided operation.

Which shall we as obstetricians choose, laparotomy or embryotomy?

[NOTE BY EDITOR.]

The question raised by Mrs. Pearman, in her excellent article, which will be especially well received as it comes from the pen of a woman, is one that has been subject to periodical or spasmodic agitation, about every twenty-five years. First, the Germans will be found the strongest advocates of Cæsarian section, but antagonized by the French and English. Then the wheel of time changes the location and the drama is produced again in France or England; but the operation meeting with fierce opposition from the balance of the world. It has ever been thus since the time of VALERIUS MAXIMUS, a Roman historian, about A.D. 12, who speaks of the posthumous birth of the philosopher Gorgias. Now that laparotomy has become a recognized operation in surgery, we hope Cæsarian section will no longer remain an unsettled question. It does seem, now, a fitting time, to place the operation where it belongs—to abdominal surgery. While hysterotomy may not be acceptable to the average obstetrician on account of its gravity or because it requires special preparation on the part of the operator, in order to justify him in the undertaking, it nevertheless should be placed as one of the legitimate measures of relief to suffering humanity.

Symphiseotomy was, for a few years, strongly advocated as the *dernier resort* in unnatural labor, but this too had its day with its supporters.

All accoucheurs agree in the opinion that, when the smallest diameter of the pelvis does not amount to two and a half inches, a delivery by the natural passages is absolutely impossible; and that we have then only to choose between hysterotomy and a mutilation (death) of the child with a possible death of the mother. But the prime factor that will be urged against this operation (laparotomy), is the want of discrimination on the part of the general practitioner as to an early diagnosis and the requisite "nerve" to urge the anxious family to submit to this dreaded procedure. After recognizing the actual necessity for an operation, numerous important questions arise for serious consideration, namely, what is the most favorable stage of the labor for its performance? Does previous duration have any positive influence

Nett

over the results ? And should the operation be performed before or after the membranes are ruptured ? Statistics show the results as follows of one hundred and sixty-four cases. When the operation was performed after the labor had lasted

	Successful.	Unsuccessful cases.
From 12 to 24 hours there were	20	40
From 24 to 76 hours " "	34	21
From 76 hours " "	8	21
	—	—
	62	82

The above table shows that the duration of the labor would have an unfavorable influence only when it has continued beyond seventy-six hours. While this shows an advantage to the mother the death rate of the children suffers by comparison. When the operation was performed

	Successful.	Unsuccessful cases.
From 12 to 24 hours,	42	16
From 24 to 76 hours,	48	24
Later than 76 hours.	11	17
	—	—
	101	57

Regarding the effect the time of the rupture of the membranes would have on the mother we report one hundred and twelve cases.

	Cases.	Successful.	Unsuccessful.
Operation performed within six hours			
after the rupture of the membranes,	39	20	19
After 6 to 74 hours,	35	14	21
Later than 24 hours,	38	13	25
	—	—	—
	112	47	65

The effect on the children was more striking.

	Cases.	Successful.	Unsuccessful.
Before or within 6 hours after the			
rupture,	37	34	3
From 6 to 24 hours after,	32	25	7
Later than 24 hours " "	37	19	18
	—	—	—
	106	78	28

It seems superfluous to add that the mortality to the foetus was much greater where extraction had first been attempted by forceps. The best time to operate for both the mother and the child is before or immediately after the rupture of the membranes.

Cæsarian section can never be regarded as a popular surgical

operation and can only be acceptable when special preparations are made previous to confinement. The success of the operation will wholly depend upon the intelligence of the attending physician. If he recognizes the narrow pelvis in time and prepares for all emergencies, hysterotomy will, most assuredly, place embryotomy where it belongs, with butchery.

The May number of this Journal will contain a brief article on Caesarian section. P. P.

OUR PARIS LETTER.

FROM OUR SPECIAL CORRESPONDENT.

A delightfully spring-like morning last week, tempted your correspondent to brave the dangers of seasickness and cross the English channel to France. Preparations were hastily made and, after farewells to a few friends and a consumptive shriek from the engine, the train was soon rolling through the suburbs of London out into a splendid farming country towards Newhaven. From the window of the car, an ever-varying panorama could be seen, long stretches of green fields, dotted here and there with quaint old-fashioned houses, and a back-ground of brown hills, almost leading one to believe it a bit of landscape taken from our own Pacific coast. In some of the cities on the road, our professional brethren are busy at their work; at Croydon we pass three Homœopaths, and one at Eastbourne.

At Brighton there are eight of our co-laborers, and here a stop is made for a call on Dr. Richard Hughes. The Doctor we find, is hard at work, as usual, as it is his office hour, so making an appointment for the future we go for a stroll on the beach. This, with a visit to the Brighton Aquarium and to the Free Library, takes up the time until Dr. Hughes is free to join us. During the discussion of dinner, the subject of *Materia Medica* naturally is referred to, as the Doctor is quite an enthusiast in that direction and is heart and soul in the work laid out by the Institute at Deer Park last year; a "Cyclopedia of *Materia Medica*."

But the time soon passes and, though we have found Dr. Hughes a charmingly agreeable companion, we are obliged to resume our travels.

A short uneventful trip, by boat and a very slow French train, brings us to Paris the next morning. Here we have letters of introduction to Dr. Claude, editor of the "*Bulletin de la Societe Medicale Homœopathique*" de France. For a call on Dr. Claude, we are rewarded, through his kindness, with cards of introduction to all the principal hospitals and to the different courses of lectures. Homœopathy in France, the Doctor tells us, is growing but in a peculiar manner. There are no homœopathic schools, but the ranks of the profession are recruited from the older physicians, who acquire a knowledge of Homœopathy by clinical experience in the wards of the homœopathic hospitals, of which, there are two in Paris. Homœopathic medicines, too, are coming into use in the old school practice; they are using Aconite, Gelsemium, Rhus, etc., but of course treating disease by name only, and making no individualization.

In fact medical teaching in Paris is (as it should be) largely clinical. The session opened in November last by lectures at the various hospitals. At the Charite hospital M. Frelat discourses on clinical surgery; at the Hotel Dieu, M. See insists in his course of clinical medicine on the necessity of combining its study with physiology, histology and pathological anatomy; at the Faculty de Medicine instruction is given in the diseases of children, by M. Legroux and M. Joffroy. Instruction in obstetrics and in obstetrical operations is given at the Clinique d'accouchements. A question that has assailed the faculty of medicine during the session is the advisability of admitting lady students to the hospital wards as "internes." The only objection that appears to have been raised, was that they would be obliged to sleep and eat in the same room with the male students. The ladies, of course, won their

case by a compromise, the faculty giving them a separate room.

Of the two homœopathic hospitals, one has been lately built, the other the Hôpital Saint Jacques is a small but neat and handsome building of red brick. The hospital is firmly established and its constantly increasing number of out patients, testify to its growing popularity. Advantages are afforded for clinical teaching but there are no students at present in attendance.

A visit to the Hôpital de la Salpêtrière also affords much that is of interest. After much red tape business and conferring with the concierge in bad French, one finally gets started, with a petite white-capped nurse for a guide. The hospital consists of a main building, with two long wings, fronting on the Boulevard de la Hôpital. Back of this, are the laundry, the department of cuisine, the school of medicine, the pharmacy, the surgery, and the insane department. To walk through and inspect all these, requires nearly four hours. The first building is devoted to aged and helpless women. In the school of medicine we find a side room devoted to the application of frictional electricity. A long bench, insulated by glass legs, seats ten persons, and to this a brass rod conducts the current generated by two immense glass plates driven by a belt from a steam engine. Truly, this is treating patients by whole-sale. From here we penetrate to the study of M. Charcot, but much to our regret do not find the great alienist at work. Evidences of his life's work are scattered around, histological and pathological specimens of nerve tissue, making up a valuable laboratory. At the school of medicine M. Charcot and M. Falret utilize the rich material of the insane department for their lectures on mental and nervous diseases.

A glance at department of cuisine, at the pharmacy and at the pleasure gardens and we hasten on to the department of surgery. The beds here, in each ward are in double

rows with the heads together. All the beds are iron, with wire springs, the floor is bare except a narrow strip of matting and all is clean and neat. Passing along, by the foot of each bed, we notice a placard giving a summary of the case, the treatment and a registration of the temperature of the patient.

What impresses one most is the immensity of the hospital in all departments and clock-like regularity with which all move together, while the constant stream of patients coming through the gates, testifies to the clinical advantages, that are claimed for its students. From Paris I go to Berlin, and will write you from the Prussian Capital.

H. H. CRIPPEN.

PERNICIOUS ANÆMIA OF PREGNANCY.

BY A. B. GRANT, M. D., Lowell, Michigan.

My only apology for reporting this case is because of its novelty and extreme rarity as observed in this country, and not that I have anything new "via. treatment" to offer.

Dec. 16th, 1884, I was called nine miles into the country to prescribe for Mrs. F. who four days previously had been confined. She had been attended by a mid-wife (the greatest curse to woman kind on earth) residing in the neighborhood, but owing to a quickened circulation and some tenderness over the abdomen, medical aid was summoned. The case was a primipara, aged about 20 or 22, and the mid-wife informs me that labor progressed naturally, (their only protection,) and not unusually severe, terminating in about eighteen hours. I found the patient with a pulse of 138, temp. $102\frac{1}{2}^{\circ}$, respiration not hurried and not labored at this time. The abdomen was quite tympanitic and there was marked tenderness, on palpation, over the umbilical and hypogastric regions, with moderate thirst. The countenance and skin over entire body pre-

sented a dirty, sallow hue, with extreme palor of tongue and gums, the sclerotic coats pearly white and glistening, the temperament being a bilious lymphatic. The flow of milk and lochial discharge normal in quantity, and to all appearance in quality.

The history of this case, as given by her mother, would show no previous serious illness, menstruation normal in quantity and regularity, bowels always constipated, evacuations once in three to six days. Body well nourished and plump. Three or four months prior to confinement the countenance began to present a pale, marble-like appearance, finally and gradually changing to that given above. Parturition was from two to three weeks premature, the child presenting the same color of skin as the mother, which cleared up at the age of ten or twelve days.

Forty-eight hours subsequent to my first visit the pulse dropped to 126 and temp. to 101°, tenderness over abdomen almost entirely subsided, patient taking a reasonable amount of nourishment, bowels relaxed but no diarrhoea. After three or four days the bowels became torpid and remained so, only moving by injections. This condition of things continued with slight variation of the pulse from 120 for about two weeks, at this time the milk had entirely dried up, but the lochial discharge continued as usual. A bellows sound—*bruit de souffle*—was distinctly audible over the base of the heart from my first visit, but no marked dyspnoea till toward the end of second week, which became quite annoying to our patient, especially at and during the night. The appetite gradually diminished, which had not been good at any time during her illness; it seemingly being replaced with an intense paroxysmal thirst, recurring every four or six hours. Finally the stomach showed signs of irritability, all kinds of liquid or solid nourishment and drinks, such as slippery elm, gum arabic and boiled water, being rejected in a few minutes after entering the stomach. Supportive treatment by

injection was suggested but without improvement, and the patient continued to sink and died on the 25th day after confinement, there being but little emaciation. There are at least two points which may be learned from this case, viz.; first, the positive correctness of the diagnosis as compared with its resemblance to chlorosis and leucæmia—which I will not here delineate—and secondly; the positive failure of drugs to reach and cure this class of cases.

INTRA-UTERINE MEDICATION.

GENTLEMEN.—I saw in the January number of the Gazette an article by Dr. L. Atthill on the treatment of intra-uterine diseases, a subject in which I am much interested. Having for nearly twenty years been making a specialty of diseases of women, my experience may be to some young men worth the space it occupies in the Gazette.

In my early practice I was often ashamed and mortified at the results which followed even warm water injections into the womb; some strong women would faint, others would be thrown into great nervous excitement, while with others no such conditions would be present. The former untoward conditions occurred much more frequently where I used medicine by injection, and my convictions are that the very delicate and sensitive internal membranes and walls of the womb should never be subjected to many of the remedies which writers on the treatment of intra-uterine ailments recommend.

Indeed, so fearful have I become of the effects of injections into the womb of any medicine, that I have almost entirely abandoned them, and instead use a probe and layer of cotton dipped into a solution of watery extract of hydrastis, or simple solution of roots hydrastis canadensis; or weak solution of carbolic acid or carbolized oil. This treatment I employ only once in about eight or ten days,

and if there are ulcers on the os I often use a solution of iodoform composed of twenty grains of the iodoform to one ounce of sulphuric ether, this to be used to the external os with a camel's hair brush once in four or six days, and alternate with a solution of boracic acid fifteen grains to the ounce of water, with twenty drops of rose water added.

This much abused and very necessary organ of the human female, called the womb, is the subject of so many disquisitions by able medical gentlemen that one sometimes thinks it should have been iron-clad to withstand all the applications of so-called medication to which the various gynæcologists have from time to time subjected it.

I can only say that I am having excellent success since I have abandoned nearly all injections into the womb, and have operated on its internal structure by a probe and brush. This, with proper constitutional medication, will go as far, or farther, in curing diseases of the membranes of the womb than all others I have ever tried; of course surgical cases may and do need different modes of management.

Of one thing I am really satisfied, and that is, that more harm than good will invariably result from injections into the womb of medicines that are very corrosive or severe.—*Therapeutic Gazette*.

SHORT-STOPPS.

Ergota: If Ergot *must* be prescribed during labor, wait until the child's head has passed out of the uterus. More cervical lacerations have been caused by the indiscriminate administration of this drug than any other measure.

Uterine Sound: In the hands of many the uterine sound is employed regardless of the condition of the uterus and often proves more injurious than beneficial to the patient. Too many cases of metritis and peri-uterine cellu-

litis can be traced to the harsh use of this necessary, but much abused instrument.

Uterine Pessaries: The moral of a lecture on the "use and abuse of pessaries." Never attempt to adjust a woman to a pesary but rather make some effort to adjust the pessary to the woman. In other words, individualize each case that requires a pessary, and if you have had but little experience in work of this character let out the job.

Pathology in Gynecology: While the knowledge of uterine pathology does not, by any means, assist us in prescribing the proper remedy, it places before us a group of remedies from which we can select the indicated drug. Too much pathology or too little, is the crying curse to therapeutists in our school. Nothing begets egotism sooner than an unequal supply of either.

Wonder where he Graduated? A homœopathic physician—we omit the state—while on the witness stand in court testified that the ordinary dose of morphine was three to five grains. In severe cases he "thought seven or eight grains would be safely tolerated by the patient." Comments are unnecessary.

Paste this in your New Spring Hat: Table for estimating the probable duration of pregnancy:

Beginning of last Menstr'n.	Quickening.	Confinement.
January 1.	May 20.	October 8.
February 1.	June 20.	November 8.
March 1.	July 18.	December 6.
April 1.	August 18.	January 6.
May 1.	September 17.	February 5.
June 1.	October 18.	March 8.
July 1.	November 17.	April 7.
August 1.	December 18.	May 8.
September 1.	January 18.	June 6.
October 1.	February 17.	July 8.
November 1.	March 20.	August 8.
December 1.	April 19.	September 7.

Female Catheterization after Confinement: After attending a case of confinement, always leave orders to notify you if the patient does not pass water at least twelve hours after delivery. If labor is not too far advanced when you enter

the lying-in room, have the patient empty the bladder. Never permit the child's head to become engaged in the inferior strait with the mother's bladder distended. This neglect on the part of the attending physician is a prevalent cause of bladder diseases. Do not hesitate to employ the catheter if you are at all in doubt.

How Long Should the Woman be Kept in Bed After Confinement? Until the womb has retreated within the pelvis, and not allowed to work until involution is complete. Before this the womb is enlarged and softened, and is subject to displacements and flexions.

Does a Woman Suffering from Nausea in Pregnancy have Leucorrhœa? We should judge they did, if a drawerfull of letters, in reply to an assertion made by one who claimed that the two marbid symptoms did not exist at the same time, was any proof. Since last year, when the ADVANCE quoted the above statement of Dr. Ludlam we have received some twenty letters citing cases to the contrary.

AMERICAN INSTITUTE.

Owing to the steady increase of material in the different bureaus of the American Institute of Homœopathy, the chairmen have been compelled from necessity to resort to all kinds of expedients and ingenuity, in order to arrange their bureau papers for presentation. Prof. Helmuth, chairman of the Bureau of Surgery, will present, as the subject for discussion, "Diseases of the Testes," while the only complete paper in the bureau will be read in full by Prof. Talbot, of Boston. The chairman of the Bureau of Gynæcology has originated a similar scheme with this difference, that a synopsis of each paper will be read and the subject for discussion presented will be, "The diseases of the Ovaries and Treatment." The following circular has been sent out to all the members of the Institute:

BUREAU OF GYNÆCOLOGY.

To each of the ten members is assigned a division of the general subject as follows:

Ovariectomy : Phil. Porter, M. D., Detroit, Mich., (Chairman.)
 Ovarian Cysts : L. A. Phillips, M. D., Boston, (Secy).
 Neoplasms of the Ovary : O. S. Runnells, M. D., Indianapolis.
 Oöphorectomy : S. S. Lungren, M. D., Toledo.
 Oöphoritis : A. I. Sawyer, M. D., Monroe, Mich.
 Ovarian Neuralgia : H. K. Bennett, M. D., Fitchburg, Mass.
 Displacement of the Ovaries : S. P. Hedges, M. D., Chicago.
 Sympathetic or Reflex Symptoms in Ovarian Disorders : R. C. Allen, M. D., Philadelphia.

Ovarian Dysmenorrhœa : Mrs. M. B. Pearman, M. D., St. Louis.

Ovarian Therapeutics : Henry Minton, M. D., Brooklyn.

An exhaustive report in each department is expected, the same to be forwarded to the chairman on or before May 1, 1885.

The only paper to be read at the meeting will be a synopsis of all these papers, prepared and presented by the Chairman (by request of members of the Bureau), and occupying only a small share of the time allotted to our report, thus leaving time and opportunity for all members of the Bureau as well as others, to speak for themselves upon their own or any other branch of the subject.

We believe that we may thus attain far better results than by consuming the entire time in the reading of papers in full or in part, and we trust every member of the Institute will take a personal interest in this much-neglected and little understood branch of medicine and surgery, and bring some clinical report that will add to the limited knowledge of ovarian diseases.

PHIL. PORTER, Chairman.

L. A. PHILLIPS, Secretary.

ABSTRACTS OF THE MONTH.

LAPAROTOMY FOR PERFORATION OF THE STOMACH AND INTESTINES.

According to Miculicz, of Cracow, (*Centralbl. f. Chirurg.* No. 45, 1884) laparotomy is urgently indicated in any case of perforation of the stomach or intestine, due either to direct or indirect violence, or to some pathological pro-

cess. Existing peritonitis should not stand in the way of the operation, as it may be thus effectually treated. The main contra-indication of laparotomy in such cases is extreme exhaustion. In the first of his reported cases, the author of this paper had to deal with peri-typhlitis, which, after a time, became complicated with constipation, vomiting, and other symptoms of intestinal obstruction. Laparotomy was performed, and an incision six inches in length made in the linea alba. The abdominal cavity contained about two pints of very fetid fluid. The intestine, though bound down by numerous adhesions, showed no signs of any disturbance in the circulation. The patient died five days after the operation, and in post-mortem examination the seat of perforation in the intestine was first discovered. The second case was a young man who, after having suffered from diarrhoea during six weeks, became constipated during the seventh week, and presented symptoms of ileus. The case was diagnosed as one of volvulus. On the performance of laparotomy one pint of turbid serous fluid was found in the abdominal cavity. A volvulus was found, and the obstruction removed. The patient recovered from the more direct effects of the operation, but after an interval of a few weeks, succumbed to intercurrent pneumonia. The patient in the third case was a young man who, having been disturbed during sleep, and having suddenly sprung out of bed, was seized with intense pains in the umbilical region, and presented symptoms of obstruction. Sixty hours after the onset of the symptoms the patient came under the care of Prof. Miculicz, who diagnosed internal incarceration, and at once performed laparotomy. In the abdominal cavity he found about a pint of thin, badly-smelling pus and some undigested pieces of potato. On the left side, just above the brim of the pelvis, a perforation, six millimetres in length and four in breadth, was observed in a knuckle of the ileum. The mesenteric glands were much swollen, and as no other

cause of the lesion could be determined, Prof. Miculicz came to the conclusion that this case was one of perforating ulcer from typhoid fever. The edges were refreshed and brought together in the long axis of the opening by a dozen sutures of silk. The subsequent course of the case was satisfactory, although the abdominal wound opened up and gave exit to a considerable quantity of pus. In the fourth case laparotomy was performed for rupture of the stomach. The opening existed near the diaphragm in the smaller curvature. The patient, whose stomach had been much distended, and whose abdominal cavity was filled with portions of food, died three hours after the operation.

VENEREAL ORGASM IN WOMAN IN PROGRESSIVE LOCOMOTOR ATAXIA.

Dr. A. Pitres, Professor of the Bordeaux Medical Faculty, narrates in the *Progress Medical* three cases in which "clitoridian crisis" were observed at the beginning, or in the course of, progressive locomotor ataxia. All three of the subjects were between forty and fifty years of age and in all the spontaneous voluptuous sensations were observed some time before the characteristic symptoms of the disease were manifested. In one of them the interval was four years. She was living with her husband, and conjugal pleasures were moderately indulged in; yet suddenly, without any lustful thought, or artificial excitement, a sort of tingling was felt in the vagina, then the clitoris was effected by the sensation, and its erection occurred, and very soon followed an undoubted erotic spasm with ejaculation, as in normal coitus. These spontaneous voluptuous crises were almost always repeated three or four in the same day, and then were absent for one or two weeks. In a second patient the voluptuous crises were present for a year, and in a third ten years before the characteristic symptoms of the disease manifested themselves.

From his observation of these cases Dr. Pitres concludes that the presence of clitoridian crises ought to lead to the suspicion of *tabes dorsalis*, even when every other symptom of the affection is absent; and that when these crises co-exist with even one of the ordinary symptoms, the disease may be diagnosticated in the absence even of all actual disorder in the coordination of movements.—*Phil. Med. News.*

ANTERIOR AND POSTERIOR DISPLACEMENTS OF THE UTERUS— THEIR MECHANICAL TREATMENT.

Dr. Macan (*American Jour. Obstet.*) summarizes his studies thus:

1. The normal position of the uterus when the bladder is empty is one of ante flexion. Hence mechanical treatment of ante flexion is rarely called for, and if symptoms be present our efforts should generally be directed to the cure of the complication.
2. In retro flexion, or versions, the primary indication is to treat the displacement. In order to do this effectually we should place the uterus in a position of exaggerated ante version, and then fix the cervix posteriorly by a pessary.
3. Hodge's pessary, or any other pessary used for the cure of retro flexion, when uncomplicated with adhesion, should act by fixing the cervix posteriorly, and not by pressing against the fundus and elevating it.
4. Versions are, so far, more serious than flexions, in that they are caused by rigidity of the uterine perenchyma, which is generally due to chronic metritis.
5. To make the results of the bi-manual examination of any use for comparison with the results of other observers, it must be made in the dorsal position, the bladder having been previously emptied.
6. A great deal of the confusion that exists about the treatment of anterior and posterior displacements origi-

nates in its being taken for granted that any treatment that is found suited to an anterior displacement must be equally suited to a posterior one, and *vice versa*. [How few physicians fully understand what the normal position of the uterus is. P.]

REDUCTION OF DISLOCATION OF HUMERUS.

The *Southern Clinic* thus gives Dr. Gissler's method of reduction :

"In my cases, the patients do not even have to sit down, and I operate thus :

1. The elbow is placed against the abdomen and then gently drawn outward until resistance is met with.
2. The forearm is then raised as high as possible toward the opposite shoulder.
3. Then the whole arm is drawn outward and the operation is finished."

This is a valuable addition to our knowledge of the operations which are daily needed. It is simple, accurate, and may be of use.

THE PREVENTIVE INOCULATION OF HYDROPHOBIA.

The *Medical News* says: The cable has recently brought to this side of the Atlantic news that M. Pasteur had discovered, isolated and cultivated, the virus of hydrophobia, and made protective inoculations with it.

The points of M. Pasteur's paper are as follows: The protective power of inoculations with attenuated virus is an established fact. The virus of rabies is attenuated by passing it by successive inoculations through the monkey. It is increased in virulence by similar passage through the rabbit or guinea-pig. In either case it can then be communicated to the dog in its modified state of virulence.

either greater or less than original, producing in one case certain death, in the other protection. The plan of action proposed is to take the virus from a rabbit dying after inoculation at a period somewhat longer than the shortest (which he assumes to indicate the greatest virulence) and inoculate this successfully in other rabbits, inoculating in the first instance from it, and in turn from each of the series of rabbits, a dog. The effect, Pasteur asserts, will be to render the dog refractory to the rabies which occurs "on the streets," that is, to the natural as contrasted with artificial inoculation.

Pasteur next asserts: "By inoculations of the blood of animals, I have succeeded in simplifying very much the operation of vaccination, and in procuring in the dog the most refractory state." He expresses the hope that he will be able, by the application of his theory, to secure immunity in animals after they have been bitten. Finally, he says he would have been happy to have published this announcement only after his conclusions had been "controlled" by some of his colleagues, but for the lack of sufficient material, and that he has asked the Minister of Public Instruction to appoint a commission to test the results of his experiments.

The scientific and humanitarian importance of this announcement is very great, and being coupled with the positive assertion of Pasteur that it furnishes an "infallible" means of preventing and curing hydrophobia, there is no wonder that numberless persons have applied to M. Pasteur and expressed their willingness to be inoculated with the modified virus which causes rabies. But, as the reaction which follows upon the dispelling of an illusion is all the greater the higher the illusion has raised the hopes of mankind, it may be worth while to call the attention of our readers to certain facts which ought not to be out of mind for an instant when weighing the claims of this promising announcement. (Continued.)

EDITORIAL.

VAGINAL DISCHARGES.

Leucorrhœa is recognized as a pathological discharge produced by the increase and alteration of the normal secretions of the genital economy. Leucorrhœa should be divided into *false* and *true leucorrhœa*, (whites). False leucorrhœa is accompanied by the presence of some foreign body like a pessary, while leucorrhœa proper, is usually symptomatic and is the result of hypersecretion. Then we have vulval mucus, which is viscous, slightly adherent to the fingers and will string out like a thread. This fluid will be found more abundant in prostitutes, due to enlarged and sensitive Bartholine glands. In young women this secretion becomes mixed with sebaceous matter, and forms a kind of magma, or smegmatous in character, with a cheesy odor. The vaginal fluid to which the name mucus has been given, (for what reason I cannot understand,) is not produced by mental or physiological causes as is the vulval excretion. It is a clear, transparent, serous fluid, having no viscosity, and but seldom seen alone. The vaginal excretion is a thick creamy fluid, never glutinous like that of the cervix and is acid in reaction. The uterine mucus is again different from the vaginal fluid. It is more like the vulval fluid but still it has its own physical characters, unlike the other excretion. There are two kinds of mucus discharges from the uterus, one from the cervix and the other from the fundus. Both can be seen appearing at the os in the form of a drop of thin transparent fluid, that often proves vexatious to the physician, when making a local application. Some writers claim there is a difference between these two secretions; the fluid from the fundus having the clear transparent appearance while that from the cervix is yellowish. This is not a point of differentiation, because when the

cervical discharge does partake of this color, it is due to some disorder of the secretion.

This is a brief preface to a table, we have taken from MacNaughton's work on diseases of women, and is not intended as a discourse on leucorrhœa, but as an introduction to the subject of the importance of differentiating discharges from the vagina. So little study is given this important branch of gynæcology that we feel perfectly justified in publishing in full, the following carefully prepared table.

DISCHARGES.

CHARACTER.	SOURCE.	APPEARANCE, PROPERTIES.
Watery (hydrorrhœal), and mixed.	Uterus—accompanying and following pregnancy; associated with malignant disease, hydatids vagina, vesico-vaginal fistulæ, rupture of ovarian cysts. Discharge frequently physiological, both from uterus and vagina; the quantity of water the vagina can secrete is shown in the profuse discharge after a glycerine plug is worn in it.	At times colorless, or mixed with blood, variously colored, with cells of different kinds, or containing shreds of decomposing debris, or hydatids, or urine.
Mucous and epithelial often containing epithelial debris, oil globules. Frequently only physiological exaggeration of the normal secretion, as in pregnancy, or associated with menstruation.	Fallopian tubes. Cavity fundus uteri. Canal of cervix uteri.	Whitish, alkaline calum-nar epithelium; at times viscid, like unboiled white of egg; when aggravated fills the cervix and os uteri as a tenaceous plug most difficult to remove, and is quite characteristic of endometritis. It may be the cause of sterility. Where the secretion is simply increased and attends corporeal leucorrhœa, it is known as "the whites," and is as a rule a proof that the general health is not good.
Sebaceous, readily becoming purulent. Pus.	Vulva, labia, vulvo-vaginal glands, sebaceous glands.	
Hæmorrhagic (excluding the hæmorrhages of pregnancy).	Purulent discharges may come from the Fallopian tubes, the result of salpingitis; from any part of the uterus, mingled with mu-	Acid reaction; varies in consistence—generally thick, creamy, white or yellowish—white adhering often closely to the os and

cus; from the vagina and cervix uteri and almost vulva. Pus may find its membranous in character; way into the uterus through squamous epithelial cells, fistulous openings, and into oil globules. Acid mucus; the vagina either by burst-character depends on the ing of a suppurating cyst, nature of inflammation; which has formed adhe- contains at times parasites sion, or the escape of pus and fungi—*Trichomonas* from a pelvis abscess the vaginalis; *leptothryx* bu- consequence of parametri- calis. Acid fatty mucus oily tis or a pelvis hæmatocele. particles, epithelial cells.

Hæmorrhagic.

Blood may pour from any The appearance of the portion of the generative purulent secretion will in tract. We have three prin- great measure depend on cipal heads under which its source and the form of we may classify the occur- inflammation that has pro- duced it; it may be profuse 1. Menstrual or altered and thick, scanty and thin, menstrual flow. 2. Disease very fœtid or almost odor- occurring in any part as in less, tinged with blood or salpingitis, metritis, endo- rusty looking, or of a dirty metritis, catarrhal cervicitis, greenish color. The dis- subinvolution, uterine charge of vaginitis is as a fibroid, polypus of any kind, rule, profuse, pouring in granulation, vascular tu quantity, and is especially mors, urethral caruncle. 3. if it be gonorrhœal thick Traumatic—injuries, opera- and yellow, and persistent. tions. Vagina—same consti- It is mingled with epithe- tutional causes as produce lium. The blood at times hæmorrhage from the is mixed with menstrual vulva; granulation; abra- discharge or is merely sion; ulceration; varicose altered menstrual flow, states; trumatic causes; excessive in quantity (men- malignant disease. orrhagia); the blood is then

Rectum—hæmorrhoids; mixed with the debris of congestion of the rectal mu- uterine tissue, epithelial cous membrane; fissure; cells, fatty and oil particles, ulcer; malignant disease; mucus corpuscles, or, if traumatic causes. Bleeding there be ulceration, pus from the rectum may and the products of inflam- accompany hæmorrhagic mation. May be arterial discharge from the vulva or venous, dependent upon and vagina. its cause, whether there is

Vulva: in the exanthe- active or passive congestion mata (variola, typhoid and due to direct rupture of ves- typhus fevers, measles; sels from ulceration and spinal meningitis; malig- slough, or their injury by nant ulceration; gangrene; laceration or wounds of noma, thrombus, varicose any kind. In the various condition;) various blood blood condition and exan- states, as in leucocythæmia themata the blood poured

and scurvy; in the hæmorrhagic diathesis; wounds, operations, coitus, from vascular excrecences, and tumours.

Air (physometra). The air is expelled by the muscular action of the vaginal walls.

Vagina and uterus: In the knee and elbow position air enters the vagina more or less readily; the vaginal walls separate. Also in the semi-prone position. Air may accumulate when a pessary is worn: if there be a fistulous communication with the bowel, or in prolapsus uteri.

Those hæmorrhages connected with menstruation and often associated with irregularity of the menstrual periods.

Uterus—1. Simple menorrhagia—physiological excess attendant upon ovulation; in plethoric states, from excess of coitus, excessive menstruation at the change of life—during the menopause; from suppressed skin secretion; the result of cold taken previous to or during menstruation.

2. Hæmorrhage due to disease elsewhere. 2. Uterine hæmorrhage dependent upon hepatic cardiac and renal affections; in phthisical states.

3. Hæmorrhage due to abnormal uterine states, associated with uterine and morbid changes in the uterine tissues.

3. Uterine hæmorrhage associated with uterine hyperplasia, subinvolution, hypertrophy; version and flexions, simple congestion of cervix or body, stenosis, metritis, endometritis, fibroid enlargement, polypi, granular states of endometrium, fissure of the os uteri and cervix, thrombus, malignant disease, extra uterine foetation, syphilitic disease, wounds.

CHAS. DEADY, M. D., secretary of the O. and O. Society, announces that in consequence of illness the transactions of 1884 will be issued next summer in connection with the proceedings of the ninth annual meeting.

CORRESPONDENCE.

GYNÆCOLOGY AND OBSTETRICS.

Dear Editor:

I cannot refrain from making some comments upon Dr. Bender's "Clinical Cases," reported in the February number of the *Gynecological and Obstetrical Journal*. In regard to his "Case I," he should have extracted the placenta before leaving his patient and before the os was allowed to contract. [Good advice when it can be carried out.—P.] The best instrument for removing the placenta is made of wire about No. 14. Take a piece twenty inches long double it and twist the ends together for a handle, leaving a loop like a narrow spoon bowl, and bent like a spoon bowl. It is easily introduced, and is better than the finger, providing the finger "could reach." With its aid you can withdraw a small placenta with ease and certainty. It is never well to let the os contract or close until the placenta is extracted; if you do there is always more or less trouble. There is no such thing as a four month's placenta being absorbed, it came away *some time*. I knew one case where the placenta was retained three months with frequent floodings, but it came away at last without much pain or flooding. "Case II" is very simple. She had not gone her full term, and it was a "false alarm." Women cannot always tell the correct time; the period of gestation is longer in some than others, and few can tell when gestation commenced to any certainty. A few days ago I was called to a primipara who was having regular pains but who said it was not time. She went eight weeks and then had "her turns," she had counted from that time. I learned that they were not natural. She flowed a little by fits and starts. I looked upon it as a threatened miscarriage and after making an examination found the cervix completely obliterated and the os dilating. I assured her she was at full time and

in a few hours she was delivered of a fully matured boy. I confess I cannot comprehend the last paragraph, and it is the only puzzling thing in that puzzling case. "Case III." The doctor is reporting obstetrical practice. This case is really a puzzle. I make no comments. J. L. GAGE, M. D.

PIN-SWALLOWING.

This feat is not uncommon among children, and it gives rise to great terror on the part of the parents. A correspondent of the *Lancet* tells us that a boy was recently brought to him who had swallowed a pin. He ordered plenty of bulky food, such as would keep the bowels somewhat inactive, and carefully avoided any aperients. Three days later, the pin was passed in a mass of fæces.

NEW PUBLICATIONS.

KIRKE'S PHYSIOLOGY. VOLUME II. *Wood's Library* for March, 1885. Wm. Wood & Co., New York.

PELVIC HÆMATOCELE. By Louis B. Couch, M. D. Reprinted from the *Chironian*.

REPORT OF THE MICHIGAN STATE BOARD OF HEALTH for 1884.

DISEASES OF THE URINARY AND MALE SEXUAL ORGANS. By U. T. Belfield M. D., Wm. Wood & Co., New York. *Wood's Library* for October, 1884.

The author has sought to give to the profession a work which shall be generally useful to the practitioner and student rather than as a work of reference. Particular emphasis is given to the statement that the physician is called upon to treat *patients* and not *symptoms*, and that cystitis, gleet, albuminuria, spermatorrhœa, are symptoms indicative of pathological change, and not diseases to be treated by routine methods. From this point of view the work will prove interesting and valuable, and shows its author to be a man of a progressive tendency. A few steps further in the right direction will bring him to that advanced stage of medical practice, wherein disease is no longer recognized as a real entity; the *patient* not the *pathology* is the subject of the physician's most earnest attention, and diagnosis is made a means of prognosis but not of treatment.

THE THERAPEUTICS OF THE RESPIRATORY PASSAGES. By Prosser James, M. D., Wm. Wood & Co., New York. *Wood's Library* for November, 1884.

As an exposition of what can be done in the way of a scholarly treatise on the therapeutics of "rational medicine" from the standpoint of the old school doctrines, we invite the careful attention of our readers to this work. The author has discussed his subject in a very comprehensive and scientific way, and has succeeded in writing a book that will well repay perusal. He embraces in his therapy not only those drugs which are used in respiratory diseases but also all those agents of whatsoever nature that may be employed to assist the patient in his improvement or recovery. Some of the subjects treated are Respiration, Food-stuffs, Aliments as Remedies, Iron, Diluents and Beverages, Exercise and Rest, Alcohol, Pneumatics, etc., etc.

EDITOR'S TABLE.

THE Brooklyn Homœopathic Hospital staff recently elected Dr. B. E. Mead president and Dr. J. L. Moffat secretary, for 1885. There are nine clinics and seventeen physicians and surgeons on the staff. Patients treated in 1884, 9,883; prescriptions made in 1884, 23,668.

THE Alumni Association of the Hahnemann Medical College of Philadelphia effected a permanent organization December 4, 1884. Any physician on whom has been regularly conferred the degree of the Homœopathic Medical College of Pennsylvania or the Hahnemann Medical College of Philadelphia, and honorary members of said institutions, are eligible to membership. The annual meeting is to be held the night before commencement.

A PARIS journal gives a brief review of the mortality of the late cholera epidemic in that city: "From November 4, 1884, to January 15, 1885—the dates of the first case admitted and the last discharged from the Paris hospitals—there were 1,080 cases, 636 males and 444 females. From these a small number must be deducted for errors in diagnosis. There were 587 deaths, or 54.15 per cent. Of the men 340 died, or 53.47 per cent.; and of the women 247, or 52.63 per cent." Although the mortality was much less than at Marseilles and Toulon, the difference in mortality is no doubt more largely due to the character of the cases at the close of the epidemic rather than the difference in medical treatment.

VIVISECTION: The friends of rational work in physiology have achieved well-merited success in the University of Oxford. Early in March in an overflowing "convocation," the battle of vivisection was fought out a third time. The victory of sound sense over false sentiment has again been won; and on this occasion the vote was unmistakable. In spite of the most vigorous exertions of the opponents of physiology, the decree to endow the physiological laboratory—as the other scientific departments in the University are endowed—has been carried by the large majority of 168 in a total vote of 656. It is to be hoped that this decisive vote will put an end to the warfare waged against the teaching of physiology in Oxford. *Science*, April 3.

THE HOMŒOPATHIC MEDICAL SOCIETY of the State of New York held its thirty-fourth Annual Meeting in Albany, Feb. 10 and 11, last, and elected the following officers: President—M. O. Terry, M. D., Utica; Vice-Presidents—A. P. Hollett, M. D., Havana; N. B. Covert, M. D., Geneva; Geo. M. Dillow, M. D., New York; Secretary—John L. Moffat, M. D., 17 Schermerhorn St., Brooklyn; Treasurer—Edward S. Coburn, M. D., 91 Fourth St., Troy.

The following censors were chosen: Northern district, Drs. George Allen, W. T. Laird and D. E. Southwick; southern district, Drs. F. E. Doughty, E. Hasbrouck and H. C. Houghton; middle district, Drs. N. B. Covert, E. B. Nash and W. E. Milbank; western district, Drs. F. Park Lewis, A. B. Wright and T. D. Spencer.

President Terry announced as chairmen of the several bureaus: Materia medica, Dr. F. F. Laird; clinical medicine, Dr. Geo. E. Gorham; surgery, Dr. T. D. Spencer; obstetrics, Dr. H. M. Dayfoot; gynæcology, Dr. Titus L. Brown; mental and nervous diseases, Dr. A. P. Williamson; pædology, Dr. Helene S. Lassen; ophthalmology, Dr. A. B. Norton; otology, Dr. H. C. Houghton; laryngology, Dr. Malcolm Leal; histology, Dr. W. Y. Cowl; climatology, Dr. Chas. E. Jones; vital statistics, Dr. A. R. Wright; necrologist, Dr. A. M. Holden; legislation, Dr. S. H. Talcott; medical education, Dr. E. Guernsey; medical societies and institutions, Dr. C. Durant Welch.

Discussion ensued on selecting a proper place for the semi-annual meeting. Grove Springs was finally chosen, and the time fixed for the second Tuesday and Wednesday of September, 1885.

A resolution offered by Dr. Paine instructing the committee on legislation to endeavor to secure the enactment of a law providing for the appointment of a State board of homœopathic medical examiners was carried, after which the usual votes of thanks were passed and the society adjourned *sine die*.

AMERICAN HOMŒOPATHIC

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AND

OBSTETRICS.

EDITED BY

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VOLUME I. MAY, 1885. NUMBER 5.

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1885.

COCAINE.

(ERYTHROXYLINE.)

Cocaine Hydrochlorate

(MURIATE OF COCAINE.)

COCAINE ALKALOID,
COCAINE CITRATE,
COCAINE OLEATE,
COCAINE SALICYLATE.

The remarkable discovery announced last October that a solution of muriate of cocaine applied to the conjunctiva of the eye produces complete anæsthesia of that sensitive membrane, has created a demand for the salts of this alkaloid which it has been difficult to supply.

Coca leaves are scarce, and held at a very high figure, and the scarcity is likely to continue for some time. We have, however, been fortunate in securing a supply of leaves of good quality, and are now in position to fill all orders for the alkaloid or its salts.

The extraordinary power of cocaine salts to obtund the sensibility of the delicate membrane of the eye has suggested trial of its powers on other mucous membranes, as those of the throat and respiratory passages, the urethra and genital apparatus, etc., and the results have exceeded the most sanguine expectations. Its almost instantaneous effect in relieving the excruciating pain in otalgia, in some cases of supra-orbital neuralgia—probably of reflex origin—and in toothache, where the nerve is exposed, should secure for it a place in the pocket medicine case of every physician.

Cocaine salts, however, have no appreciable action on the deeper tissues unless given by hypodermic injection, but when so administered are capable of affording great relief in some painful affections. The medical journals are full of accounts of the triumphs of this new local anæsthetic, which is sure to hold a rank hereafter in the materia medica with opium and quinine.

We offer the following preparations of cocaine:

COCAINE ALKALOID.

In 1 gramme vials, per gramme...\$5.00
In 5 and 10 grain vials, per grain.. .35

COCAINE CITRATE.

In 1 gramme vials, per gramme... 5.00
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COCAINE MURIATE, salt, amorphous.

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COCAINE MURIATE, 2% solution.

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THE AMERICAN HOMŒOPATHIC JOURNAL.

—OF—

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No. 5.

NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal, should be exclusively for its pages; no others desired.
2. Illustrations required for original contributions, will be furnished at the expense of the journal.
3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
4. Personal controversies, not being of interest to the profession in general, cannot be published. Explanations may be made through the editor. This rule will be strictly adhered to.

THE USE AND ABUSE OF OBSTETRIC FORCEPS.

C. A. WALSH, M. D., Detroit, Mich.

Although in skillful, and especially discriminating hands, obstetric instruments must be regarded as great blessings to the suffering sex, yet it is a question with some practical men, whether by their unnecessary and improper use they have not produced on the whole more injury than good. During the long reign of barbarous surgery, there is ample evidence to prove that instrumental interference was often most unjustifiably had recourse to; and there is good reason to fear that many women have dragged on a miserable existence to the end of their days, the miserable victims of impatience, ignorance or violence. There is also the same cause of apprehension that in no few instances, the child's, if not the mother's life, has been sacrificed, when patience, perseverance, and reliance on the natural powers, were the only obstetric auxiliaries re-

quired. I would not have it thought by these observations that I am unable to appreciate the advantages resulting from instrumental aid; or that I would draw an argument against a valuable measure from the possibility of its abuse. I know too well that nature sometimes fails even in her grandest and proudest work—the continuance of the human species; and that occasionally both the mother and her offspring would be overwhelmed in one common fate, unless art stepped in to snatch them from impending destruction. I would endeavor to deeply impress upon the mind of all, and particularly the young practitioner that urgent necessity alone will warrant him in taking an obstetric instrument in hand, and that when a choice is allowed him he should leave nature to accomplish her own purpose, provided indeed, he can with safety trust her. It is an old and to a certain extent a true observation, that “meddlesome midwifery is bad.” The right use of the obstetrical forceps demands a thorough knowledge of four things: First, the instrument itself, its form, design, and capabilities; second, of the place with which it is to be introduced, viz., the maternal passage, its form, direction, and mutual relations; third, of the body upon which they are to be applied, viz., the child’s head, its form, consistence, and toleration of manipulation; fourth, of the normal mechanism of labor or the manner in which the child should be delivered by the natural process, for the forceps are not a foreign and unnatural resort, like the Cæsarean section, but are intended to assist, supplement and conform to the course naturally observed in labor. Before attempting their introduction the membranes must of course be ruptured, the os should be fully dilated and the cervix retracted over the head. Still these two points cannot be regarded as many have laid down, as being *sine qua non*. Dr. Robert Lee crystallized the prevailing opinion of the British practitioners of a few years ago, with the following words: Said he, “There are few practitioners of judge-

ment and experience, who have recourse to forceps, or who employ it before the orifice of the uterus is fully dilated, and the head of the child has descended so low into the pelvis as to make an ear to be felt." As a legitimate consequence of this practice, when the powers of the uterus failed to cause the head to descend so low as to enable us to feel an ear, a condition which quite frequently occurs, *perforation* must needs be resorted to, and a life sacrificed. If we appeal to the records of English lying-in-hospitals, the correctness of this deduction will be amply verified. In a comparative view of the frequency of forceps and craniotomy cases, as shown by the records of eleven lying-in-hospitals of Great Britain, the forceps were applied only once in every 617 cases, while craniotomy was resorted to once in every 141 cases, thus craniotomy was resorted to about 4 2-5 times oftener than the less destructive mode of delivery by the forceps. To the average mind, the enormous craniotomy practice and consequent destruction of life, shown by the English records of but a few years ago, is chargeable in a large degree to the opinions then held, forbidding the timely use of the forceps, except in a very limited number of cases. In Germany they reach the opposite extreme, using the forceps once in every seven cases, while craniotomy was performed only once in 2,093 cases. In France the forceps are employed once in every 263 cases, craniotomy once in every 1,854 cases, (Churchill Amer. Ed.) In this country we do not possess sufficient obstetrical records from which to construct a positive comparison and average between these two methods of artificial delivery, yet it is believed that we occupy a happy medium found between that of the French and Germans. This great difference in the application of the forceps between the English on the one hand, and the Continental European and American practitioners on the other, is a significant fact which we should not overlook, inasmuch as it seems to argue very conclusively that, either from defect in mechan-

ism of the instrument, or from a flagrant want of proper rules as to their employment, our British brethren have so often in the past, had recourse to a most fearful operation on occasions when, in this country and in Continental Europe, a timely use of the forceps would obviate its necessity, and save human life.

In a practice extending over the space of twenty years, and with a very considerable experience in obstetrics, I have had no occasion to resort to craniotomy in a single instance when the case was my own *de novo*. Twice during this period I have been called upon to assist others when this operation was required, and in both instances, I feel justified in charging the necessity of mutilating the child, and its consequent death, to the teachings of Burns, Denman, Davis, Ramsbotham and Churchill, and those who taught after their system. In both cases the attending physicians had delayed a resort to the forceps, in obedience to the rules they had learned, until their successful application became impracticable and I am of the opinion that in both cases, the delivery could have been brought to a successful termination, by the early resort to the forceps, and the lives of one or both children saved. I am aware that the medical profession everywhere has taken an advanced step in this department of obstetric practice, and I submit herewith some of the more recent views published. Dr. More, England, maintains that the obedience to the rule of the old teachers, "that the use of the forceps should not be had recourse to so long as the foetus makes any advance," is fraught with evil, both to the mother and child. He further says: "The timely use of the forceps shortening the second stage of labor, is the *great practical* improvement of midwifery." His statistics show that the assisted cases get up and are about sooner, and feel better than those left entirely to nature. The class of cases in which forceps are deemed justifiable, and even obligatory are; First, all cases when the first stage is

completed, and the head remains stationary. In these cases I would not wait more than two hours. Second, in cases where, though the head is advancing the labor is rendered tedious, from the fact of the pains being too weak, or having almost ceased; third, when the pains are stronger than is warranted by the advance made; fourth, in cases of hæmorrhage, especially severe; fifth, in some cases of convulsions, possibly in all cases when it is practicable to adjust them; sixth, in all cases favorable for operating, when the patient is very desponding or impatient; seventh, in cases of occipito-posterior presentation and not advancing quickly; eighth, in cases of the second twin, if a head presentation, and not advancing quickly; ninth, to save time if the case is favorable to relieve the woman and himself from work.

In tedious labor from debility the forceps are preferable to ergot; it prevents exhaustion of the uterus, and hence diminishes the chance of flooding. I am of the opinion that it is exceedingly doubtful if in cases of contracted pelvis, it is not safer to let the case go to term, then see what nature can do; next the forceps if there is room in the pelvis; craniotomy or Cæsarean section, as a last resort. Turning in these cases does not present any advantage to the mother over the long forceps in contracted flat pelvis, and is more dangerous to the child. It is wholly inadmissible when the pelvic contraction is general, and more dangerous than the long forceps, or any of the higher operations. In cases with a large head in proportion to the pelvic capacity, or with a head having the fontanelles preternaturally ossified, and the second stage having been reached, if the pains were feeble and not easily provoked, or if strong and no advancement being made, I would not wait for half a day or so, as I would have done twenty years ago, but after giving nature a fair test of from four to six hours, I would complete the labor with the forceps. And so with those cases where, for hours, our patient is annoyed with weak

and ineffectual labor in all the degrees, from pains which merely cause the abdominal tumor to descend without any appreciable advancement of the foetal head, to complete inertia of the uterus, I regard it as good practice,—all the conditions for operations being present—to apply the forceps after waiting from two to four hours, according to the more or less complete absence of uterine effort.

These are the classes of cases in which I have more recently resorted to the forceps, thereby increasing the ratio of instrumental to the whole number of cases, and I am heartily satisfied with the results obtained by this method of treatment. My patients thus operated upon have invariably gotten up speedily, and made good recoveries. From a paper published in the *Virginia Medical Monthly*, 1884, Dr. Moon says in regard to the use of the forceps: “When the resistance of the soft parts offers the chief obstacle to labor, there are two conditions to which I wish your attention called. The first is when the head lies high up in the excavation and entirely within the uterus, the waters having escaped and the mother is proving restless, apprehensive and weary, the head has been lying down upon the neck just within the os-externum for some hours, without being able to accomplish necessary dilatation; the os is partially dilated, and by manipulation with one or more fingers is capable of being dilated to two-thirds of the extent required for the passage of the child’s head. Here, after dilating the os to the extent and in the manner above described, apply the forceps, being careful in no way to involve the soft parts, and then by gentle and slow traction you will be able to deliver the child, saving the mother hours of suffering as well as the infant the risk of being born asphyxiated. So soon as this condition is positively ascertained, the accoucher should at once interfere and deliver, never being governed by any formulated set of rules as to the number of hours that should be permitted to elapse before interference should be considered justifiable. The

other condition is when the head has descended to the floor of the perineum and apparently is retained by the resistance of the perineal muscles. Here the head will frequently remain for hours without advancing, and despite all efforts of the uterus, aided by the voluntary efforts of the mother, the obstacle remaining the same, instrumental interference will be required to accomplish delivery. The impression is generally prevalent that it is simply the rigidity of the perineal muscles that thus retards the labor. It is rather attributable to the peculiar direction in which the force is applied to the head of the child. The head in descending remains in a flexed condition until it impinges upon the floor of the perineum, at which time it becomes necessary in order to complete the labor, that *extension* should begin. These are the cases where forceps can be applied with great ease to the accoucheur, with but slight pain to the mother, and if the delicate short forceps is used, neither the integrity of the soft parts of the mother should be in any way compromised, nor the head of the child injured. The latter assertion I expect to be caviled at, so far as it relates to the soft parts of the mother; but I am firmly convinced that the lacerations of the perineum more often follow protracted, obstructed labor, over-distending of the perineum, than the application of the forceps, and I do not exaggerate when I state, that nine out of every ten cases requiring the application of the forceps, is after the head has reached the floor of the perineum, and not until then. It is for this reason, the general practitioners should learn how to apply the forceps, and thus afford relief, which is quite often needed at their hands to women in the throes of labor, leaving the higher operations which require an educated touch, and great delicacy of manipulation to those endowed with eminent skill." Tears of the perineum will occur whether the physician uses the forceps or not; but in a majority of cases they come from the use of the forceps, or rather from the abuse of the forceps. It is good prac-

tice generally when the proper time comes, put on the forceps and boldly bring down the head; but when it begins to bulge the perineum, take off the forceps. Very few are competent to deliver the head over the perineum with forceps. The temptation is to turn the head too quickly. If you take off the forceps you will rarely have a bad tear, and if it does occur you will not get the blame of it. It is a very rare thing for me to end a labor with forceps on. There is such an abuse of this instrument that I sometimes think that Bandelocque was right in the statement that the forceps had done more harm than good. It requires great skill and judgment to end a labor with the forceps. A physician from inexperience, or being demoralized by a long and tedious labor, is liable to use undue violence and deliver the head too quickly, or to make traction in the wrong direction. I have myself torn the perineum, and seen many good physicians do the same. Occasionally our blade will catch over one ear and you cannot get it off, but in the majority of cases it can be removed and that is the proper thing to do.

A SIMPLE AND EFFICIENT SURGICAL OPERATION FOR INCOMPLETE LACERATED PERINEUM.

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I will not attempt to give a complete essay upon this subject, but will endeavor to bring out certain points, a knowledge of which is essential to a clear understanding of the operation which I will describe. It is meant for the secondary operation on the perineum, not the immediate. The names of Dieffenbach, Langenbeck, Baker Brown, Sims, Simon, and Emmet are all connected with improvements in this method of operating, and the works of Savage and Hart on the anatomy of the female pelvis have made clear doubtful points about the structure of the perineum.

While an interne at the Woman's Hospital, twelve years ago, I saw several cases that had been operated on for laceration of the perineum, admitted for a second operation on account of the skin and mucous membranes stretching to such an extent as to form merely a thin covering over the rectocele and prolapsed organs behind it. I made drawings of several of these cases, one of which I still happen to have. For years I thought that failure in these cases had been due to the fact that the operator had not cut away enough tissue and put in his sutures deep enough. I did not recognize the fact that the old crescent-shaped denuded surface, which was made to include a large part of the labia and skin, only reunited the superficial and everted part of the perineum. Simon improved upon this by denuding a triangular strip upon the rectocele; and Dr. Emmet improved on this when he introduced the clover-leaf denuded surface; but both of these leave undenuded the retracted edges of the pubo-coccygeus muscle and pelvic fascia in the angles depressed on either side of the rectocele.

Five years ago I adopted a plan of operating, which I think is an improvement on either Simon's or Dr. Emmet's operation, and I have been teaching this operation at the Polyclinic and at Bellevue for the past three years. It is simpler, and, I think, secures better results than Dr. Emmet's last new operation.

I accept with slight modification Hart's views as to the manner in which the uterus is sustained by the pelvis, and also that the perineum does not directly sustain the uterus in position, but under great intra-abdominal pressure it is a support to the pubic segment, and thus limits prolapse of the pelvic contents. The best proof that it only indirectly affects the position of the uterus is, that when the perineum is completely divided so that the fecal matter escapes voluntarily, the uterus, as a rule, will be found in about its normal position. In seven cases of complete

laceration operated upon by myself in the past two years, in five the uterus was in good position, and in only one was there retroversion and prolapsus. In the remaining case the uterus was somewhat prolapsed, but not retroverted. The escape of fecal matter was the only complaint. I know of one woman who has borne five children with the rectum and the vagina torn through within an inch of the cervix uterus.

My observations and study long ago led me to think that one of the chief functions of the perineum is not, as Dr. Emmet expresses it, to sustain the rectum—for when the perineum is completely destroyed the rectum remains in place—but to enable the rectum and anus to perform their functions, and not allow the intra-abdominal force necessarily exerted to empty the rectum, to disturb the equilibrium of the pelvic organs and overstretch the pelvic fascia and ligaments. Excepting during expulsion of the child, the greatest force (intra-abdominal) that disturbs and displaces the pelvic organs is straining at stool. It is this force which stretches the ligaments, and when, as it so frequently is in women, greatly increased by constipation, causes reaction of the perineum even when it has not been lacerated. And it is this force that causes rectocele, cystocele and hernia of the organs of generation. Standing and walking may cause pelvic congestion, and when prolapse is well advanced, may add to it; but the intra-abdominal force caused by the erect posture is insignificant compared with straining at stool, for the pelvic and abdominal organs are all suspended independently of the perineum, and downward pressure from the diaphragm falls mainly on and in front of the pelvic bone.

Just after the birth of the child the pelvic ligaments and perineum are relaxed and yielding, but the abdominal walls are also relaxed and intra-abdominal pressure is for some weeks very slight.

To make plain the reasons for doing the operation as I

propose, I usually describe the perineum as the movable point of attachment for the transversus perinæi, the bulbo-cavernosus, the sphincter ani, levator ani, and some of the pelvic fascia, and also as the movable point of attachment for the anus and lower end of the rectum, and the lower end of the posterior wall of the vagina. It is composed chiefly of firm connective tissue, such as forms the ligaments of muscles in other parts of the body; and as consisting of two parts, the outer or superficial, and the deeper or inner part. Externally we have the transversus perinæi, the bulbo-cavernosus and external sphincter ani, some of its fibres forming the internal sphincter ani, and the pelvic fascia which sweep down from the sides of the pelvis and help to form and strengthen the pelvic floor, and make with the fibres of the levator ani a firm ligamentous band at and in front of the lower end of the rectum, just where it joins the anus. It is this band which, being pulled up by the action of the levator ani, deflects the fecal matter backward and outward through the anus, as it is forced down the curve of the sacrum by the contraction of the gut and the compression of the intra-abdominal force exerted by the diaphragm and abdominal muscles. The ligamentous band not only prevents the fecal matter from being forced forward out through the vaginal outlet, carrying with it the posterior wall of the vagina, thus forming a rectocele, and, by dragging on the posterior vaginal wall, tending to retrovert the uterus by pulling the cervix downward and forward, but it sustains the anterior wall of the vagina and bladder when forcibly pushed downward by severe intra-abdominal pressure, such as is exerted in straining at stool. The external perineum may be torn and cause little or no trouble, but when the inner part of the perineum, where the rectum merges into the anus, is torn or much relaxed, while the sphincter ani remains intact, then we have perversion of the immense intra-abdominal force needed to expel the fecal matter.

The muscular fibres of the pubo-coccygeus muscle that should encircle the vagina, united in front of the rectum and into the anus, are separated and the pelvic fascia is torn loose; thus the rectum is forced forward and downward, and we have rectocele; and the anterior wall is gradually overstretched and forced out through the open vagina, forming in time a rectocele and true hernia. When the perineum and sphincter ani are completely severed, then the fecal matter passively escapes, and we have no rectocele and very little prolapse.

When both the external and internal parts of the perineum are partially torn, there will be in time eversion of the lower end of the vagina, the ostium being everted and rolled out, while the inner part of the perineum is retracted laterally, forming the deep angles on either side of the rectocele.

In restoring the perineum, we must denude these depressed angles and insert our sutures so as to bring the retracted edges of the pubo-coccygeus and pelvic fascia into apposition up over the rectocele, otherwise we merely partially reunite this band that directs the action of the rectum; and where there is a real necessity for an operation to restore the perineum, we make a failure. The screen of mucous membrane and skin will look well for a while, but only lasts a short time.

I do not agree with Dr. Emmet when he says that the tearing is transverse, and not from before backwards. I think that the usual tear starts by the tissues in front of the muscular wall of the anus separating, and then instead of tearing through into the anus and rectum, the tissues tear laterally around the end of the vagina and anus, thus separating the attachment of the levator ani and pelvic fascia which holds in place the end of the vagina and anus; this explains why the deep scars are usually to one side or other of the rectocele. The anus and lower end of the vagina are thus partly torn loose from the levator ani,

which, when torn, retracts laterally and inward, while the vagina and anus are prolapsed and the vagina everted.

My operation consists in denuding, not the skin or tissues covering the labia, but the mucous membrane that once formed the ostium vaginae only as high as the old caruncles, laterally and gradually extending the denudation upward for an inch to an inch and a half in the vagina, going laterally so as to include the depressed angles on either side of the rectocele in these angles, removing the mucous membrane and connective tissue until firm white tissue is reached, and up over the rectocele to the opposite side, but only taking off the mucous membrane over the elevated part of the rectocele, so as not to injure the muscular structure of the vagina. The denuded surface, when completed and spread out, instead of being crescent-shaped or triangular, or like a clover leaf, is nearly square, with its longer axis extended up the vagina, except where the rectocele is large, then it may have its long axis running from side to side. Now the sutures are put into the superficial perineum in the same way as in the old operation, as was done by Dr. Simms thirty years ago; the third or fourth suture usually being inserted with the ostium vaginae, but the three or four last ones are entered within the vagina and passed from the right side, dipping deep laterally, completely under the denuded angle and under the denuded surface of the rectocele to its centre; then the needle is re-entered at the same place in the centre of the rectocele and carried completely under the depressed denuded angle of the left side, and brought out in the side of the vagina opposite its point of entrance. The last one is passed in the same way and made to include the edge of the undenuded vagina, so that, when it is tightened, no undenuded surface is left in the vagina.

After all the sutures are inserted, usually numbering six or eight, I then thoroughly stretch the sphincter ani; this relieves tension in that direction, lessens the risk of

troublesome hemorrhoids and fissures, and when the sutures are tightened, the external perineum is drawn upward and inward, the most prominent part being that next to the rectum.

Before the sutures are introduced, the rectocele presents a convex surface, but when silver wire is used, after being inserted and the ends pulled upon, as the depressed angles are more fixed than the movable displaced rectocele, it will be depressed to the level of the angles and present a concave surface in place of the convex surface, and usually the same sutures can be tightened and closed with very little tension at any one point.

In old cases of long standing, where the tissues are infiltrated and more or less atrophied, the tension is considerable, but dilatation of the sphincter relieves this tension and enables you to close the edges and bring the angles well together over the top of the depressed rectocele.

Of course, before operating the patient is carefully prepared by curing up any uterine diseases existing, and the general circulation of the parts improved by the use of glycerine and alum pledgets. The vagina is always well washed with a solution 1 to 5,000 mercuric bichloride, and antiseptics used for sponges, hands and instruments. After the operation is finished about twenty grains of iodoform are powdered over the sutures. Each time that the patient passes water the parts are washed with a weak solution, 1 to 1,000, mucuric bichloride, and fresh iodoform put on.

No catheter is used except when the patient is unable to pass her urine. The bowels in all cases are made to move by mild laxatives once a day. No bandage is put about the knees, and the patient is allowed food as she wishes it. In cases of pain morphine is given. I sometimes have twenty successive cases without having an accident of any kind, or without seeing any pus or even swelling to any extent. I

attribute this largely to cleanliness, the use of iodoform and to the dilatation of the rectum.

This operation is efficient in restoring the perineum when it is relaxed or when the tear is submucous, and when carefully done it will successfully close the perineum when the sphincters are completely severed. Except where the vagina is lacerated very extensively, I rarely use any other than silver sutures passed from side to side and twisted together in the vagina. In old women with complete procidentia, after restoring the cervix, which in such cases is often lacerated, and where the anterior wall is excessively relaxed and stretched, I may carefully denude it and sew in a fold with catgut sutures; at the same time I restore the perineum as I would for laceration, but as the vagina is no longer to be used, I extend the denudation higher on the sides and further up on the posterior wall, so as to almost entirely occlude it. In some of these cases the tissues have so completely atrophied and degenerated, that they may give way unless the patient is kept recumbent for several weeks after the operation. In young women who may bear children I am careful in denuding the tissues, and do not extend the raw surface but very slightly above the retracted angles on the sides of the vagina, for if we destroy much tissue the next child will be sure to tear the perineum. I prefer silver wire, and always take interrupted sutures. Since we understand the importance of cleanliness and the proper use of antiseptics, either silk, gut or silkworm, or even good catgut, will give good results.

I prefer a straight, round, pointed sewing-needle about an inch and a half long, which with Sims' needle-forceps can be readily passed. I enter the needle close to the undenuded surface and carry it well into the tissue, and take pains to see that it passes beneath the depressed angles and gets a hold in the retracted muscles or fascia; with the index finger in the rectum the point of the needle is easily

guided, and the fascia when caught up can be plainly felt on the stretch.

For dissecting the mucous membrane, I use a good pair of dissecting-forceps in place of the orthodox tenaculum, and I take pains to see that all loose cellular tissue is removed, so that union of firm tissue is secured where the ligaments and muscles have been torn.

The stitches are removed on the tenth day, and the patient allowed to sit up four or five days later, but is instructed to take care for at least six weeks. Intercourse too soon after the operation may tear or overstretch the perineum,

Regarding the perineum as the movable point of attachment for the transversus perinæi, the bulbo-cavernosus, the sphincter ani, levator ani, and some of the pelvic fascia, and also as the movable point of attachment for the anus, and lower end of the rectum, and the lower end of the posterior wall of the vagina, the conclusions are:

First.—As a rule, when the perineum is completely severed so that the fecal matter escapes passively, the position of the uterus is not affected.

Second.—The external or lower part of the perineum may be torn to a considerable extent and the position of the uterus not affected.

Third.—When the inner and upper part of the perineum is torn or overstretched and relaxed, prolapse of the posterior and anterior vaginal walls will take place, and in time the uterus is retroverted, prolapsed, and may be forced out of the pelvis.

Fourth.—The explanation is that when that part of the perineum formed by the fibres of the levator ani and pelvic fascia, where they encircle and are attached to the lower end of the vagina and anus, are torn apart, and the lower end of the vagina and the upper part of the anus are loosened so that they are not held up and elevated when intra-abdominal force is exerted, as in straining at stool, both

are forced out through the vaginal outlet, and they pull and drag down the uterus, and in time result in hernia of the pelvic organs.

Fifth.—In operating to restore the parts, we should aim to reunite the separated edges of the levator ani and pelvic fascia, and fix them to and in front of the lower end of the vagina and the anus, and lower end of the rectum.

Sixth.—This can be done efficiently only by denuding the retracted tissues on either side of the rectocele and uniting them over the rectocele. As the most important laceration is within the ostium vaginae, to reach these tissues the operation must be within the vagina; and to secure good apposition and to avoid dragging down and adding to the tension, most of the sutures should be passed within the vagina from side to side.—*Medical Record.*

LONDON NOTES.

THE HOSPITALS.

(From our own correspondent.)

For the number and wealth of its charitable institutions, London is rivalled by no city in the world, and yet, although they are supposed to administer to all the ills to which human flesh is heir, they are able to alleviate only a portion of the misery that exists. Some idea of the vast system of hospitals and dispensaries may be obtained from statistics. The dispensaries number nearly one hundred, of which six are homœopathic; the hospitals include 27 General Hospitals, 82 Special Hospitals, 20 Convalescent Homes, 4 Homes for incurables, 5 Lying-in Hospitals, and 1 Homœopathic Hospital. These institutions contain about 8,000 beds, receive annually 60,000 patients and give medical advice and medicines to hundreds of thousands of out-patients, through their dispensaries. Among the general hospitals, those most deserving of mention are the London

Hospital (800 beds), Guy's (710 beds), St. Bartholemew's (676 beds), and St. Thomas (620 beds); the last is especially worthy of inspection, as it consists of seven fine buildings, being undoubtedly the most magnificent establishment of the kind in England.

When we come to speak of Hospitals for Diseases of Women there is much that is interesting; this special class includes eight devoted to this purpose, while each general hospital has wards set apart for gynæcological treatment. The staff of medical officers in attendance include the well known names of Sir T. Spencer Wells, Dr. Robert Barnes, Dr. Lawson Tait, Dr. Wm. Playfair, Dr. A. W. Edis, and Dr. Matthews Duncan. In the Soho Square Hospital for Women, the first of its kind that was established, a large amount of good work is being done; all of the beds, numbering 63, have been occupied and during the last year 573 patients have been admitted. Of these 40 per cent. were discharged cured, 46 per cent. relieved, 1.6 per cent. unrelieved, and 25 or about 4 per cent. died. In the out-patient department 4,980 new cases have been seen; while the total number of attendances were 24,558, about 490 a week.

Outside of the hospitals much is being done in gynæcology and obstetrics. The Obstetrical Society of London has been the source of many important papers; notably Dr. Graily Hewitt's paper on the "Vomiting of Pregnancy," Dr. E. S. Tait on "Puerperal Temperatures," and Dr. Matthews Duncan on "Fœtal Revolution." The reading of each paper has been followed by prolonged discussion, especially that of the "Vomiting of Pregnancy," in which Dr. Graily Hewitt advances the question as to the extent of the influence of morbid conditions of the uterus in giving rise to the disease. He analyses a tabulated arrangement of two series of cases; the first, of thirty-two cases, in which the conditions of the body of the uterus were noted, and a second series of thirteen cases in which the conditions of the os and cervix uteri were particularly

described. In the first series, the uterus in twenty-three was in a state of decided anteversion or ante flexion, in one slightly anteverted, and in four retroverted. In the other series of thirteen cases the cervix is described as very hard in four instances. The author concludes: "(1) That the cases in which the disease is due to some other organ than the uterus are so few in number that they may be almost excluded from consideration. (2) That in the large majority of cases the disease presents itself during the first half of pregnancy. (3) That evidence points to interference with the normal expansion and growth of the gravid uterus as a condition of the production of this dangerous affection, and that this is most frequently brought about by or in connection with detention of the bulk of the uterus in the bony pelvis; in eighty-eight per cent. the uterus being ante flexed or anteverted and twelve per cent. in a state of retroversion; the other conditions met with being hardness, resistance or unusual rigidity of the os and tissues of the cervix. (4) There appear to be two factors to be considered capable of interfering with the expansion of the uterus: (a) incarceration with flexion or version; (b) undue hardness and rigidity of the os and cervix; these may be conjoined in a given case. It appears to be borne out by the facts recorded that the incarceration is the most important of the two factors, as a rule at least." As to treatment the indications are to secure the normal upward movement of the fundus uteri by absolute rest in a supine position, if anteversion be present, or on the face and side if retroversion exists; these measures may be aided by gentle pressure with the fingers internally or by an air ball, and the position maintained by a pessary. Failing in this Cope land's procedure of dilating the cervix should be employed. If these measures are applied sufficiently early, the last resort, induction of abortion, it is believed, will be rendered unnecessary.

Aside from this the formation of a new gynæcological

society is being agitated; an organization meeting being held last December, at which the first meeting was appointed for April. As many prominent gynecologists are active movers in the new organization, it is to be hoped that the association may result in giving to us the fruits of their experience. Among the new things in gynecology is the application of the local anæsthetic virtues of cocaine to the mucous tract of the vagina. Several cases are reported of its use in very severe vaginismus, by painting the vaginal orifice with a solution of the hydrochlorate of cocaine, of strength varying from four to ten per cent., conjoined with the introduction of a vaginal suppository containing the same drug. Used in this way it answers admirably, entirely removing the spasmodic contraction so that the speculum or finger can be passed without pain, thus rendering easy what before could not have been accomplished without chloroform. The use of cocaine has done much for ophthalmic surgery and seems to promise much for the condition just described.

THE LONDON HOMŒOPATHIC HOSPITAL AND MEDICAL SCHOOL.

But in digressing from the subject of hospitals, we must not forget the Homœopathic Hospital. This institution, the protege of the British Homœopathic Association, was founded by this society in 1849. Since then, by endowments and subscriptions, it has been fostered until it has become firmly established and its prosperity is an indication of the success of Homœopathy. Among its patrons are many of the peers of England; Lord Ebury being chairman of the Board of Management. The number of beds is about 70; of in-patients treated during the year, 543; of out-patients, 8,404. In gynecology 38 cases were treated, including nearly the whole list of diseases of this description; of these seven were cured, 20 much improved and the remainder are either under treatment or discharged uncured. Not much seems to be done in surgery, only 11

operations being performed; but all received benefit from the treatment.

The condition of the medical school in connection with the hospital is somewhat deplorable, but this is unavoidable under the laws of England, the graduates from the homœopathic school being obliged to graduate first from allopathic schools before the law sanctions their practice. This has had the result of driving the students from this school, so that during this year no lectures have been delivered. The prospect for the next year of the school seems no better than that of this year. But aside from this the condition of Homœopathy is very successful. The practitioners enjoy a large share of the patronage of the upper classes.

H. H. CRIPPEN.

LONDON, ENGLAND, Jan. 30, 1885.

PELVIC HÆMATOCELE, WITH A NEW AND SUCCESSFUL MODE OF TREATMENT.

LOUIS B COUCH, M. D., Nyack-on-Hudson, N. Y.*

At 8 A. M., November 13, 1880, I was called in great haste to see Mrs. J. A., age thirty-six, mother of four children. At 7 A. M., while at stool, she was taken suddenly with a sharp, sickening pain in the region of the right ovary, accompanied by severe rectal tenesmus which greatly increased her pain and suffering. With great effort she went to the house and laid upon the bed, being too ill and weak to be undressed.

The pains increased in severity and gradually extended over the abdomen, which was, especially in the right ovarian region, extremely sensitive to touch or pressure.

Great thirst, profuse vomiting, and a thin, watery diarrhœa were present. Patient complained of feeling "awfully weak." The extremities were cold as those of a corpse.

*From the Chironian of Feb. 12th, 1885.

The ears, nose, and face were ashy pale and very cold. Lips pale and bloodless. Pulse small and weak.

I administered Arsen.^s Ipec.^s Verat.¹, as seemed indicated. Patient, however, grew steadily worse. Medicines and all liquids were immediately rejected. The pains being excruciating, I endeavored to allay them by subcutaneous injections of one-eighth grain morphia. They utterly failed to relieve or even mitigate the suffering, and about midnight, fifteen hours after the commencement of the attack, death suddenly and unexpectedly occurred. The patient was conscious to the last.

I made no positive diagnosis. I had never seen a case like this before. I was certain, however, that the principal cause of death was hæmorrhage from a ruptured blood vessel in the region of the right ovary—though the dreadful pain in that immediate locality led me also to suspect a ruptured ovarian cyst of acrid contents into the cavity of the peritoneum. I obtained the consent of the husband to a post-mortem examination, and twenty-four hours after death, assisted by Mr. T. F. Tasman, the undertaker, I opened the abdomen from above downward. A free flow of dark, fluid blood followed the section in the epigastric region. On increasing the opening to the pubes, the pelvis was found to be filled with dark blood, clotted and fluid. The right fallopian tube was about one inch in diameter, and contained a foetus in the early weeks of gestation.

On the upper portion of the dilated tube which was dark, thin and friable was a triangular rupture about one-fourth inch in length from which the blood had slowly poured out into the abdominal cavity. No evidences of peritoneal inflammation existed. My patient had bled to death while I was hunting for a remedy to relieve the intense pain, vomiting and diarrhœa.

The thought that had I treated this case in a common sense way, instead of wasting time in attempting to relieve reflex symptoms, by the useless administration of drugs

that were immediately rejected, I might have saved a valuable life, made a deep impression upon me and I resolved that if I ever had another case of Pelvic Hæmatocele I should discard drugs entirely and treat it on scientific principles.

On June 9th, 1884, on the same street and within a stones throw of my former patient I was called to see Mrs. Bloodgood, age twenty-two, married, and the mother of one child. I obtained the following history:

For about two weeks patient has been in the habit of walking in her stocking feet on the cold stone pavement of her cellar, which foolishness has resulted in a suppression of the menses which are now about ten days overdue.

At 5 P. M. to-day she went to stool and while straining, was suddenly taken with a very severe sharp pain in the region of the right ovary accompanied by a terrible straining and bearing down in the attempt to void a passage. I saw her at 7 P. M. in bed. She was still dressed, the extreme suffering preventing her from disrobing. The rectal tenesmus had greatly increased the pains, which now radiated all over the bowels and across the back. They were especially severe, however, in the right ovarian region. Abdomen intensely sensitive to touch or pressure. Has vomited profusely, first liquids and finally blood.

I found the patient with her head raised high upon pillows. Eyes half open and turned up, exposing the sclerotic. She was stupid and dull though groaning with the intense pain. Speech was slow, hesitating and difficult. Face, nose and ears cold, clammy and ashy pale. Lips white and bloodless. Extremities icy cold and so numb that a deep pin prick was not felt. Wrist pulse weak and small.

My diagnosis was Pelvic Hæmatocele. I removed all the pillows and prohibited any movement, straining or attempt to void a stool. Remedies seemingly indicated were of not the slightest use. In one hour all the symptoms had

increased steadily in severity. The wrist pulse was now gone, though the heart was still beating feebly. Patient was apparently moribund. She looked like death itself. Life seemed hanging as by a thread. I recognized the fact that unless something was done immediately this patient would speedily follow the other to that place appointed for all the living. Drugs, however, were out of the question; if given they would be immediately rejected, and if retained they would be at best of doubtful efficacy. The usually advised ice cold applications to a person in the extremity of collapse seemed worse than useless, almost criminal. Here the thought occurred to me to place the patient in a position so as to give the brain the benefit of the little blood remaining in circulation and prevent at the same time any further hæmorrhage from the ovarian vessels.

I raised the foot of the bed four feet higher than the head (about an angle of 60 degrees) and left the patient in this position for thirty-six hours.

This experiment, though simple and easy of application, proved to be of the greatest efficacy and value to the patient.

The pulse soon appeared again at the wrist and hourly grew in strength and fulness as the effused blood in the abdominal cavity was reabsorbed. Aside from a sensation of oppression of the chest, consequent upon the pressure of the abdominal viscera and effused blood against the diaphragm, no disagreeable symptoms were noted.

In thirty-six hours the bed was again placed in a horizontal position, but all excitement or motion strictly prohibited for another day.

Stimulants were of course interdicted till all danger of recurrent hæmorrhage had passed, though milk, beef tea and soups were given *ad libitum* as soon as the stomach could retain them.

In three weeks my patient was up and attending to the lighter of her household duties, and in one month was as

well and strong as ever. In due time the menses returned as usual and without incident.

I have carefully examined all the authorities at my command, and have conferred with many of my professional friends to learn if the procedure I have advocated had ever been recommended in this disease, but without success. I think I may, therefore, lay claim to originality in first advocating this positional treatment of Pelvic Hæmatocele—a treatment at once easy of application, eminently practical and always available.

It stops at once the loss of blood, relieves the anæmia of the brain and subdues the almost unsufferable tenesmus, and, last but not least, it obviates the need of pouring into an extremely irritable stomach such disagreeable drugs as turpentine, lead and gallic acid, as advised by even the latest authorities—a practice which seems to me to be little better than barbarous, and a good deal worse than useless.

ABSTRACTS.

RECENT PROGRESS IN THE DIAGNOSES AND TREATMENT OF THE DISEASES OF THE FEMALE URETHRA.

The *Maryland Medical Journal* speaks thus editorially:

Some six years ago, Dr. Emmet devised the plan of making a button-hole like opening in the female urethra for the purpose of forming a diagnosis, or for facilitating operative procedures. It has been due to the use of this method of exploration that we now have an exhaustive and practical study of urethral affections. Dr. Emmet does not now hesitate to announce the fact that this method is the only one within our knowledge to-day which fulfils every indication for exploring the female urethra.

In the latest edition of his book, Dr. Emmet describes fully this method of operating, and gives a number of illustrative cases showing the results of this plan of diagnosis

and treatment. A classification of the diseases of the urethra shows that this organ may be affected with growths and with thickening from inflammation of its mucous and submucous tissues; "the canal may be dilated from before backward, and with more or less prolapse of the mucous membrane along the urethra from the bladder; its lining membrane may be diseased in part or throughout; or fissures may exist at the neck of the bladder." For these conditions we have had no efficient means to aid in forming a diagnosis, until Dr. Emmet devised this button-hole operation.

The importance then of this operation can be fully appreciated in its general bearing upon the diagnosis and treatment of urethral disease. At first thought the distress and reflex disturbances occasioned by growths, fissures, and inflammatory conditions of the mucous membrane of the urethra may appear to be exaggerated phenomena, but we cannot think Dr. Emmet has overdrawn his estimate of the influence these conditions may exercise upon the female economy. Dr. Emmet is known to be a most careful and painstaking observer. The clinical facts he offers carry with them the weight and force of strong conviction.

Laceration of the female urethra is a condition which, perhaps, few clinical observers have recognized; yet Dr. Emmet informs us that since his attention has been called to the subject, he has found evidence of urethral laceration as common as that of the perineum, and far more so than the injury through the sphincter ani. The result of this lesion is a too patulous urethral outlet and more or less prolapse of mucous membrane. This prolapse, presenting itself at the outlet of the urethra, projecting from the upper or lower portion of the passage, or occupying the entire circumference of the canal, impedes the escape of urine from the bladder, and, as the obstruction increases more or less tenesmus is constantly excited, which in time adds to the difficulty. "Ultimately the whole urethral

canal becomes displaced, and pressed forward or rolled out by a prolapse of the super-incumbent tissue about the neck of the bladder."

In the recognition of this condition, an important advance has been made in the treatment of urethral troubles.

Urethrocele is another important subject considered by Dr. Emmet. This condition has been frequently attributed to laceration of the perineum. Dr. Emmet attributes it to an injury of the urethra direct; the laceration of the perineum preventing a proper support, the condition of the urethra could not improve afterwards, and becomes exaggerated in consequence. He believes in the beginning of every case of urethrocele more or less laceration has taken place between the longitudinal fibres of the urethra. This condition is easily remedied by removing the excess of tissue, and by then denuding the sides of the opening in the urethral tract to a sufficient width, so that when the two surfaces are brought together by sutures the urethral canal will be restored to its natural calibre.

In the examination of growths on the uterine wall, it has been claimed that dilatation of the urethra offers superior advantages. As is well known, this operation is not devoid of evil consequences. Permanent incontinence after the operation will occur in a certain number of cases, as a result of lacerations of the urethra. The consequences which follow such a procedure are serious enough to give rise to doubt as to its propriety. Dr. Emmet, having given most careful study to this subject, asserts that the alleged advantages in no degree compensate for the risk, particularly since an artificial opening in the base of the bladder gives equal facilities for exploration, and is attended by no such risk of incontinence.

[The simplicity and usefulness of this button-hole making in the urethra is, perhaps, a little overstrained. It may be easy for one who is accustomed to operating upon

the pelvic organs, but most surgeons will find it quite troublesome to make the opening, and more difficult to see much of the interior of the urethra after the opening is made. Most of the diseases of the urethra can be diagnosed by simpler means. Again, if we except lacerations of the urethra, all other diseases of that part were fully diagnosed before Dr. Emmet made the button-hole. We have had a few of his cases that were "button-holed" at his sanitarium, and we humbly beg to be excused from any more.—P.]

PREMATURE LABOR.

BY AUGUSTUS P. CLARKE, M. D., Cambridge, Ma.s.

Dr. Clark reports two cases and writes as follows concerning the methods of performing the operation.—The plan of inducing premature labor by the introduction of a flexible gum elastic bougie, is evidently a safe and easy method. My experience in the use of sponge tents, even when thoroughly carbolized, for dilating the cervix for any purpose whatever, is unsafe and often leads to irreparable mischief. For a long time I have abandoned their use altogether. The use of a flexible gum elastic bougie is more scientific. The bougie is cleanly, its presence in the uterine cavity, across the fundus, after a few hours, will often excite healthy and normal uterine contractions. In any case where any unpleasant or any constitutional disturbances arise from its presence, it can be readily removed by the attendant, or the patient herself, before alarming or serious symptoms supervene. The bougie is also applicable in cases in which it is desirable to induce abortion for the relief of obstinate vomiting of pregnancy, that sometimes threatens the life of the patient. I have used it for such a purpose and have found it a most valuable means of emptying the uterus of its contents. Digital dilatation, when carefully and judiciously practiced, is also a most valuable

means in any case where the emptying of the uterus is urgently and speedily demanded.

An important consideration in a case where the induction of premature labor is required, is to ascertain when the time has arrived beyond which pregnancy should not continue. This can only be decided by careful consideration of the whole history of the case. From my experience in the above cases, as well as from my general obstetric practice, I would state that in no case should the induction of premature labor be undertaken until after a most thorough study or knowledge has been gained of a previous pregnancy, or pregnancies, for it is absolutely impossible to obtain any definite and reliable knowledge relative to the dimensions of the pelvis until after labor is well advanced or immediately after it has been completed.

INDUCTION OF PREMATURE LABOR.

BY T. GAILLARD THOMAS, M. D., Prof. of Gynecology, Coll. Phys. and Surges
New York.

The method of inducing premature labor which I now invariably adopt is very simple, and, at the same time, a perfectly efficient one. The patient is placed across the bed, with the buttocks resting near the edge, and under her is arranged a large piece of rubber or oil-cloth in such a way as to drain into a tub below on the floor. In this tub we put one or two gallons of water of a temperature of 98° F. The operator stands between the thighs of the patient, whose knees should be properly supported and employing a syringe with a long nozzle, which is carried up as far into the cervical canal as it will go, he keeps a steady stream directly against the membranes. In the course of ten minutes the os will be the size of a silver half dollar, and when dilatation to this extent has been accomplished, he is to insert a gum catheter between the membranes and the uterine walls. The patient is then put in bed, and that is all.

This operation constitutes one of the greatest advances that have ever been made in the obstetric art, and it is certainly no mean triumph to be able thus to preserve a human life which, without its aid, would have been inevitably lost. I can point to at least two dozen children in this city, who by this means were saved from an untimely fate. When the infant has been delivered before full term, it should not be washed and otherwise treated in the ordinary manner of nurses, but should be carefully wrapped in warm cotton and allowed to remain in it; the temperature of the room in the meanwhile being brought up to nearly one hundred degrees.

IODOFORM IN UTERINE COLIC.

In a paper by Dr. W. A. Sellman, read before the Medical and Chirurgical Faculty of Maryland, at the annual meeting 1884, he recommends the use of strong solutions (80 grains to the ounce) of nitrate of silver as the best application in cases of endometritis. He has found it decidedly escharotic and alterative, and he has obtained better results from this than from any other application. A serious objection to its use, however, is the frequent production of severe uterine colic, either immediately or within an hour after the application.

He has found that the application of iodoform immediately after the nitrate of silver is a complete relief of the intense colic. He generally applies the iodoform by means of a cotton-wrapped applicator. In cases where the contraction of the cervical canal is so sudden as to prevent the application in this manner, he uses a medicated uterine suppository or bougie.

[Would it not be better to prevent the colic by avoiding the treatment which gives rise to it, than to cause it and then cure it by iodoform.

Having heard of a man who prevented a bad attack of

hydrophobia by getting upon the top of a fence until the mad dog went past, we take a hint and will suggest that patients keep out of the way of an 80 per cent. solution of nitrate of silver, and thereby avoid the need of treatment for uterine colic.]

CÆSARIAN SECTION.

BY S. S. LUNGREN, M. D., Toledo, Ohio.

Apropos of the subject of "laparotomy versus embryotomy," in our April number, by Mrs. Pearman, comes a report from Dr. Lungren of an operation performed by him last month of this same character. The woman had been in labor *five days* previous to the operation, thus presenting from the outset, an unfavorable aspect.

The child had been dead for some time, and the membranes ruptured. The incision in the uterus was seven inches long. This is the third cæsarian section performed by our esteemed colleague, twice before on the same patient. We shall give a full report of the case in our June number.

IOWA. HOW IS THIS?—In an editorial of "*The Iowa State Medical Reporter*," the profession is rated in the following manner: "Iowa is the illiterate physician's paradise, no requirement being made for the practice of medicine. If a man or woman has the gift of gab, lots of cheek, especially if he or she can dress well and make a good appearance, they will succeed in making a practice. The less education the better. Little or no moral character is required, either. This is the status of the medical profession in Iowa."

"No man is so good a diagnostician as he who understands the exceptions to the rule."—*Hyde*.

DR. EMMET says (Principles and Practice of Gynæcology pp. 715): "In this country I do not know of any prominent operator who now employs the carbolic acid spray."

BOOK REVIEWS.

INSOMNIA AND OTHER DISORDERS OF SLEEP. By Henry M. Lyman, A. M., M. D., Professor of Phys. and Diseases of the Nervous System in Rush Medical College, Chicago. Published by W. T. Keener, 96 Washington street. 1885.

The relations of sleep to the nervous disorders and insanity, are so estimate that a thorough treatise on this physiological factor of health, giving due consideration to its normal and abnormal relationships, is a welcome addition to a library. The opening chapter is devoted to modifications of physiological functions during sleep, the condition of respiration, circulation, secretion, nutrition, and calorification. In the pages given to this discussion we find but little original; clippings from other authors constitute the larger part.

In the explanation of the relation of mind to sleep, there is an apparent confusion of the nervous force, constituting the mind with a spiritual force, and we find this remarkable statement "the mind sleeps, it does not cease to exist—probably not even when death dissolves the material substratum." This is an essential fault of the theological philosophers; but the mind is not the soul, and with it as a nervous force in connection with medical science, theologians have nothing to do. In taking up the causes of sleep, the author places himself among those that believe in the theory of a change in the molecular structure of the brain, but since he farther says that this, in our present state of knowledge, must be represented as a consequence of deficiency in the amount of oxygen, we must take this latter statement as a virtual admission that sleep is dependent upon a condition of cerebral anæmia. The chapter on the causes of insomnia is excellent, and arranged in a scientific manner. The classification into "Insomnia caused by irritation of the periferal portions of the sensory apparatus," and "Insomnia caused by morbid states of the central nervous organs," with three subdivisions in each class, is especially pleasing and leads to a clear understanding of each cause. The remedies for insomnia are those of the usual armamentarium of the allopathic physician.

Dreams, somnambulism, and hypnotism occupy there mainder of the book, but are of little practical interest, since these chapters only contain a review of the remarkable actions of patients during such states of the mind. The work is well written; in fact, much better than the average, showing care and attention to the arrangement of his matter considered.

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COCAINE.

(ERYTHROXYLINE.)

Cocaine Hydrochlorate

(MURIATE OF COCAINE.)

COCAINE ALKALOID,
COCAINE CITRATE,
COCAINE OLEATE,
COCAINE SALICYLATE

The remarkable discovery announced last October that a solution of muriate of cocaine applied to the conjunctiva of the eye produces complete anæsthesia of that sensitive membrane, has created a demand for the salts of this alkaloid which it has been difficult to supply.

Coca leaves are scarce, and held at a very high figure, and the scarcity is likely to continue for some time. We have, however, been fortunate in securing a supply of leaves of good quality, and are now in position to fill all orders for the alkaloid or its salts.

The extraordinary power of cocaine salts to obtund the sensibility of the delicate membrane of the eye has suggested trial of its powers on other mucous membranes, as those of the throat and respiratory passages, the urethra and genital apparatus, etc., and the results have exceeded the most sanguine expectations. Its almost instantaneous effect in relieving the excruciating pain in otalgia, in some cases of supra-orbital neuralgia—probably of reflex origin—and in toothache, where the nerve is exposed, should secure for it a place in the pocket medicine case of every physician.

Cocaine salts, however, have no appreciable action on the deeper tissues unless given by hypodermic injection, but when so administered are capable of affording great relief in some painful affections. The medical journals are full of accounts of the triumphs of this new local anæsthetic, which is sure to hold a rank hereafter in the materia medica with opium and quinine.

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1. All articles or communications to this journal, should be exclusively for its pages; no others desired.
 2. Illustrations required for original contributions, will be furnished at the expense of the journal.
 3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.:
 4. Personal controversies, not being of interest to the profession in general, cannot be published. Explanations may be made through the editor. This rule will be strictly adhered to.
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CÆSARIAN SECTION.

PHIL PORTER, M. D., Detroit, Mich.

Now that Cæsarian section or hysterotomy has become a recognized surgical operation and the question relative to the merits of the two procedures, in case of a narrow pelvis, of embryotomy or laparotomy, is engaging the attention of the medical profession, we give, in a condensed form, the different steps of the operation. This operation should only be practiced on a woman when the natural passages, through which the child has to pass, are too narrow to permit of the delivery by forceps or otherwise. It should also be resorted to when there is a possibility of saving a child when the mother dies from any cause, in the latter part of her gestation. The general practitioner should always be prepared for this emergency and if he is not endowed with the requisite qualifications for performing this operation, know where he can turn to, in a dilemma

of this nature and have reasonable expectations of assistance.

The operation is by no means a rare one in America and is becoming more and more firmly established every year on a basis of justifiable means, in surgery. Statistics show that during the eleven years preceding 1867, there were performed 25 Cæsarian operations and previous to this, for a period of ten years, there were 29 operations. From 1845 to 1855, both included, there were 22 Cæsarian sections. In other words, a careful examination of reports elicits the information, down to 1878, of an average operation of $2\frac{1}{2}$ cases every year; since which time there has been a steady increase to an average of 4 cases annually. It is interesting, too, to note the different operators and their location, showing that no one surgeon had succeeded in establishing for himself a special reputation in this particular department. In 1867, Dr. T. Beers Townsend of New Haven, Conn., Dr. Aquin, and Dr. D. Warren, both of New Orleans, each had a case, while the fourth was performed by the writer's preceptor, Prof. Abram Sager, at Ann Arbor, Mich., in 1869. The various operations, following the above were performed by Drs. Paul, Marmon, and Rodenskin, of Kingsbridge, N. Y., Dr. T. A. Foster, of Portland, Me., Dr. John V. P. Quackenbush, of Albany, N. Y., Dr. E. L. Griffin, of Fond du Lac, Wis., and Dr. T. Gaillard Thomas, of New York. In 1875 Drs. A. B. Jones and Kline performed the operation at Portsmouth, Ohio, while in the same year and in the same state, at Toledo, our colleague, Dr. S. S. Lungren had the honor of having successfully performed the operation on a patient, upon whom he again operated during her next pregnancy. The following year Michigan fell into line through her representative, Dr. O. P. Barber, who operated at Saginaw City. In 1877 Dr. E. W. Jenks, of Detroit, operated successfully. Since this time there has been a gradual increase in the number of these operations, and we are able to report

about seven cases every year. Without attempting to enter more fully into the history of Cæsarian section in this country, for this article does not cover that field, we will proceed to the consideration of the operation.

Hysterotomy like ovariectomy requires certain preliminaries that always, to a greater or less degree, affect the results of the operation. In cases that have afforded an opportunity for an examination, early in gestation, to diagnose a narrow or contracted pelvis, special attention should be given to a correction of any morbid condition that may exist or would be liable to give rise to any emotional disturbance.

When the operation has been fully decided upon, the temperature of the room should be raised to 80° F. and this degree maintained during the time that the abdominal cavity is exposed. We know that this precaution is not regarded by many operators as of any special importance, but our experience and results demonstrate otherwise.

In calling attention to minor details in preparing both the patient and operator, understand us as not wishing to appear too particular, and yet we feel perfectly justified in referring to every thing that will add to the comfort of the patient and to the success of the operation. It is our practice to shave that part of the abdomen which will be included in the adhesive straps, to remove all the fine hairs on the surface that are found so sensitive in after dressings when the straps are removed. The patient's clothing should be protected from all discharges and water, which will also be appreciated by her or her attendants. After satisfying ourselves that the rectum and bladder have been thoroughly evacuated—the operator should never soil his own hands with the use of the catheter before the operation—and the lower extremities protected with a blanket, we proceed with the operation. It is necessary to have two competent assistants besides the person giving the anæsthetic; one to handle the sponges and the other to assist in manipulating the abdomen.

The operator should stand on the right of the patient and the assistants on the left. The abdominal incision should be made through the *linea alba* and carried from the umbilicus to the pubes. The incision should be made so as to cautiously expose the peritoneum. Before opening the peritoneal cavity, all bleeding points in the tissues on each side of the abdominal wound should be carefully secured so that as little blood as possible may pass into the abdominal cavity. On reaching the peritoneum it may be picked up with the forceps or tenaculum, and "nicked" with the knife. Into the peritoneal opening thus made, the index finger, peritoneal knife, or director may be introduced and the tissue divided to an extent corresponding to the abdominal opening.

As soon as the abdominal viscera are exposed, care must be taken by the assistant to prevent the escape of the intestines. This may be best done by a large thin, flat sponge about 12 inches square, wrung out of hot water and placed in the abdomen, pushing back the intestines to protect them and at the same time expose the uterus. These precautions fulfilled, the next step is the incision of the uterus itself. This must be done with as even a stroke of the knife as possible to avoid producing rough and jagged edges, and should be carried as high up in the uterus as possible without dividing the fundal structures so far as to wound the large anastomosing vessels or dividing the tissues so as to interfere with the efficient contraction of the womb itself. The especial object of a high incision is to avoid bringing the lower angle of the uterine wound below the inferior angle of the abdominal incision. Avoid wounding the child when dividing the uterine walls. Hæmorrhage should be controlled with hæmostatic forceps or small clamps. Now comes the time when an intelligent and level-headed assistant is of value to the operator; the walls of the uterine opening should be grasped by the assistant and brought in immediate contact with the edges

of the abdominal wound and held firmly until the membranes have been divided and the child extracted, after which the uterine contractions will compel him to release his hold. After the first uterine pain, the placenta can, as a rule, be released from its bed. One precaution should always be taken which is of great importance in the result of the operation, and that is, to keep the abdominal cavity free from all discharges.

Certain rules are laid down in obstetrical works relative to the manner of extracting the child, but our advice is to grasp the first extremity that presents; usually the head is found impacted in the pelvis and naturally the feet will come first to the hands of the operator. The cord should be treated as if the delivery were natural. Some operators advocate allowing the placenta to be delivered *via. naturalis*, but this is, we think, bad practice. If the uterus does not contract sufficiently to separate the placenta a little vinegar applied to the edges of the incision of the uterus will produce the desired effect. Care should be exercised before closing the uterine wound to remove all of the secundines and clean out the blood clots.

Closing the uterine incision:—A great diversity of opinion prevails regarding this step of the operation as to the proper kind of sutures to be employed; some advocating silk floss, others silk worm gut, cat gut and horse hair, while the majority cling to silver or iron wire. We favor the silver on many accounts. It more readily becomes encysted and is less irritating than any other. The claims for the animal preparation of suture, that is absorption, is not borne out by facts, in abdominal surgery. The number of sutures introduced, rests with the judgment of the operator; some cases requiring ten or twelve sutures, while others but four or five. Perfect apposition of the divided walls is of the utmost importance. If the os uteri is not sufficiently patulous to permit of ready escape of all discharges, provision must be made; but we do not recom-

mend the introduction, and leaving, of anything in the os to keep it open, that will act as an irritant to the uterus and produce contractions.

The abdomen should be closed as in ovariectomy, employing as few sutures as possible and yet secure perfect coaptation of the peritoneum—a very essential step in the operation—and the abdominal walls. The filling of the tissues along the incision with a mass of foreign substance, to not only act as a local irritant but mechanically to interrupt circulation, is, we think, open to criticism and poor surgery; too many sutures are as detrimental to union of the wound as too few, and to strike the “happy medium” requires judgement and experience. We usually introduce two or three silver wire sutures, according to the length of the incision, with which the edges of the peritoneum are carefully and accurately brought together, to be secured later with buck shot, over perforated lead shields after the balance of the sutures have been introduced. For the other sutures we employ, silk worm gut, introducing them about an inch apart, which we pass entirely through all the abdominal tissues including the peritoneum. With this treatment, which we have followed, for four years, we have never been unfortunate enough to have a single case of intramural abscess or peritonitis, in any abdominal operation. We seldom resort to superficial sutures. We have seen cases where the tissues of the entire edge of the abdominal incision were gangrenous, three or four days after an operation, due to strangulation of the parts by too many sutures, both deep and superficial. Our rule is to employ as few sutures as possible and yet secure perfect coaptation of the wound.

The after treatment of the case is of vital importance and requires skill and judgement. No set rules can be laid down for this part of a grave and important operation. This part of the treatment usually rests with the attending physician, and if the operator resides at some distance

from the patient, a great responsibility is thrown upon his shoulders, one that will not rest lightly either. It is here that an intelligent practitioner can play an important part in the result of a Cæsarian section or an ovariectomy. If the temperature rise to 102° or to 105° , the abdominal water coil is of great assistance, but don't, we beg of you, resort to the non-homœopathic, non-scientific, but empirical habit.—nothing else—of prescribing ten, fifteen, twenty or thirty grains of Quinine. With proper application of water in various ways, sponging the surface, irrigation, and coils, both for head and abdomen, *and the indicated remedy*, the temperature can be lowered without expense to the economy at large. Just as sure as you lower the temperature of the body by large doses of Quinine, brought about through its sedative influence on the nervous system, just so sure do you jeopardize your patient's life by impairing her energy and lowering the vitality of the system. The practice is one introduced by a school that is compelled to resort to such severe measures in emergencies, through ignorance of therapeutics, and should not be blindly followed by any one who calls himself a Homœopath. While you, in your weakness, imagine that you have accomplished wonderful results with your Quinine, your homœopathic brother has done equally as well, if not better, with his medicated drug and has a much better condition left with which to continue, than the "Quinine stuffer." A reaction always follows the administration of large doses of this lazily, confessedly ignorant (the prescriber acknowledges his ignorance by the prescription), foolishly, criminally, prescribed drug, "a la regular."

It may be unnecessary to add that the patient should be protected against the admittance of friends or annoyed by any conversation; or, in fact, disturbed in any way for the first five days.

FETAL NUTRITION.

BY H. H. CRIPPEN, M. D.

Nutrition whether in the vegetable or animal kingdom is one of the absolute and fundamental necessities of life. It has no single purpose; it is not for the promotion of mere growth, but subserves other purposes, those of growth and repair of waste.

Beginning with the simple cell, the original nucleus of the embryo, we perceive, through the successive stages of growth and developement, the transmutation of that comparatively insignificant structure into a type of the most perfect organism, as displayed in man. Throughout the whole life of the human organism there is no period marked by such rapid growth and developement as during intra-uterine existence, so that we may see the necessity for a large and abundant supply of nutritive material and the demand for an organ capable of presenting nourishment in such a form as to be readily and easily taken up by the elementary organism.

Such an organ we have in a placenta or something equivalent, which is to be found in connection with the young of every living creature. In the oviparous animals the substitute for a placenta is found in the membrane of the vitellus which serves as a surface from which is absorbed the albuminoid substances, fat, mineral matters, and the water necessary for the nutrition growth and developement; while the membrane surrounding the albumen is utilized as a medium through which changes, analogous to those effected by respiration, are wrought in the blood contained in the ramifications of the umbilical vessels of the chick.

In viviparous animals the subject of foetal nutrition presents in a more complex form, and considering the difficulties in the way of close study of the placental structure

NOTE.—Read before the College of Physicians and Surgeons of Michigan.

it is not surprising that so many theories are extant. By distinguishing two different periods of foetal nutrition, first, embryonic nutrition, that previous to the placental formation, we find that it is mainly as to the latter period that our physiologists differ.

All agree that from the period that the fecundated ovule becomes detached from the ovarian vesicle until its entrance into the uterine cavity it is dependant upon what is known as yolk nourishment. (Of course if it be proven that fecundation takes place in the uterus, this is *nil.*) But unlike the young of the oviparous tribe, this source of sustenance soon becomes exhausted by the embryo of mammals so that when the latter is lodged in the uterine cavity it finds its elements of nutrition in the fluids which are poured out in abundance by the uterine follicles.

With the increased growth of the embryo there comes a demand for a greater supply of materials for development necessitating the establishment of a more intimate bond of union between the maternal and embryonic structures. Now though all authorities admit that the placenta forms this intimate union, it is from the different theories as to the mode in which that organ performs its nutritive function that the diversity of opinion has arisen.

Concerning the function of respiration as carried on by the placenta, the fact that oxygenation of foetal blood takes place by the process of osmosis, seems to be universally admitted at the present day. Passing over the subject of foetal respiration with these words we arrive at the special object of my paper, namely, to bring to your notice the theory most lately advanced; that originating from the researches of Prof. G. B. Ercolani of Bologna, as to the fact of the maternal portion of the placenta in all animals being a glandular organ of new formation which is developed for the secretion of a fluid, analogous to milk, serving the purpose of foetal nutrition.

The old time theories have ever been unsatisfactory and

changeable. A very ancient theory referred the nutrition of the foetus to the amniotic fluid. In the American Journal of Obstetrics, Vol. XVII, page 810, Dr. Anderson of San Francisco, serves this up to us again as a *new* theory. He adduces six propositions in support of the theory, all of which are well taken except the last, which I consider the turning point, "the mechanical difficulties opposing direct nutrition through the placenta;" this as will be shown later is provided for and what he considers a "mechanical difficulty" becomes the phenomena of glandular tissue.

The belief regarding the blood as passing from the maternal arteries to the foetal vessels may easily be proven fallacious by the process of carefully injecting the two sets of vessels, showing that no fluid passes direct from the maternal to the foetal side of the placenta. When the fact of an uninjected space remaining in the placenta between the two sets of vessels was established, the theory was advanced by Mialhe that, since pure albumen will not dialyze, there exists in the blood of the parent an element capable of percolating membranous tissues. This substance he called albumenose and claimed that it was this, which passing by a process of dialysis from the blood of the mother to that of the child, supplied the foetus with nourishment. That this substance existed in the maternal blood during pregnancy was also demonstrated by Robin and Verdeil; microscopical sections however show more than a mere membrane existing between the foetal and maternal structures, with glandular elements, so that it is more than probable that this element in the blood, if it supplies the foetus with nourishment, undergoes a change in the new glandular formation of the placenta.

It is worthy of mention that our physiologists, while they have not made clear the subject of foetal nutrition, have had an inkling of the truth. Foster in his late edition of physiology says, "while we have no definite knowledge

as to the exact form and manner in which nutritive materials are conveyed to the young; yet since the placenta is remarkable for the great development of structures apparently of an epithelial nature, it has been suggested that it forms a temporary digestive organ." Farther along he comes nearer the truth when he admits that from the "placental cotyledons of ruminants may be obtained a creamy looking fluid which might be almost spoken of as uterine milk."

Earlier writers than Foster, however, have contributed facts toward the support of the theory of the existence of uterine glands. As early as 1681 Malpighi in describing his researches writes that he observed in different species of animals, specially well seen in the sheep, openings in the uterine mucous membrane, and to this he adds that the uterine glands increase during pregnancy. These observations were not repeated until about one hundred and fifty years later. In 1828 Baer, also observing these same glands took them for lymphatic vessels and it was not until several years later that he recognized their glandular structure.

In the publication of the fourth edition of "The Human Anatomy of Hildebrand" in 1832, E. Weber claims for himself the honor of being the first to recognize the existence of uterine glands and of having named them utricular glands, besides giving a description of them in the uterus of the cow and the doe. But while we can not deny to Weber the merit of establishing beyond question the existence of the uterine glands, still in view of the poverty of means at the disposal of Malpighi, it is but just to accord to the great anatomist of Bologna the admiration and honor due him for his masterly inductions made in the absence of the auxiliaries of modern science.

Later Eschricht of Copenhagen confirms the observations of Weber and adds his own researches on the uterine glands of the dolphin and cat noticing also the increase in volume during pregnancy in the latter animal. He also

teaches clearly and distinctly that the uterine glands elaborate a fluid destined for the nutrition of the foetus.

These researches confirm more and more the idea of a secretion by the utricular glands of a fluid which may be absorbed by the foetal portion of the placenta. In further confirmation, we find Sharpey, Bischoff and Gurlt affirming that, the villi of the chorion enter into the openings of these glands. With the addition of some observations by Prof. Spiegelberg in later times, in which he declares that the openings in the maternal cotyledons, into which the villi of the chorion penetrate, are but remarkable expansions of the uterine glands, we find that this has been the condition of science from Malpighi's time to a recent date.

Ercolani now brings to our notice an article which is the result of a very exhaustive, thorough and elaborate research, and puts a negative on some of the foregoing deductions and affirms others. The result of his investigations may be best summed up in his own words as follows:

"There is produced in the pregnant uterus of mammals, including the human species, a glandular organ of new formation. This organ constitutes one of the two fundamental portions of the placenta, that is to say, the maternal portion, with which the foetus is brought into intimate relation by the villi of the chorion, which composes the other portion of it or the foetal part.

"The villi of this latter part of the placenta penetrate always and obviously into the glandular organ or maternal part, in order to absorb the fluid which is there secreted, and thus to furnish the foetus with the materials for its nutrition.

"The typical form of the new glandular organ does not depart from the common form of a simple glandular follicle of the animal organism. Likewise the typical form of the foetal placenta or absorbing portion is that of a vascular loop more or less elongated, or that of a villus."

In endeavoring to understand these conclusions it is

necessary that we recognize the existance of a uterine mucous membrane, in woman, of the simplest form, that represented by a simple epithelial pelicle. The function of the uterine mucous membrane is distinguished most fundamentally from that of other mucous membranes of the animal organism by the marvelous transformation which it undergoes during pregnancy. This modification that takes place upon the uterine surface is connected with the formation of the membrane which has been called the decidua serotina as distinguished from the decidua reflexa and the decidua vera by being that part of the mucous membrane upon which the ovum rests and where the villi of the chorion are developed in greatest abundance.

The decidual membrane in woman is a product of organic materials elaborated by the internal surface of the uterus and by the uterine follicles and consequently cannot be regarded as a swelling of the uterine mucous membrane but must be considered a neoplasm or new formation. This neoformation is especially true in the decidua serotina which arises from a layer of large cells furnished by the submucous connective tissue of the uterus. These large neutral cells are the stroma whence the maternal or glandular portion of the placenta takes its origin.

The cellular structure of the serotina which lines the uterine surface of the placenta is also observed upon the foetal surface covered by the chorion where the cells of the serotina are blended with the connective tissue. It is therefore plain that the serotina penetrates into the interior of the placenta where its cells are transformed at different points into true fibrous tissue, more especially to circumscribe the large lacunæ of the placenta which contain maternal blood. Further the serotina clothes the villi of the chorion throughout their whole extent and in their numerous ramifications to the interior of the placenta. Every where the cells of the serotina offer examples of the greatest and most rapid modifications. The most remarkable

consist of the sheath which the serotina furnishes to the villi of the foetal placenta as far as the chorion.

This sheath is formed on the exterior by a fibrous membrane and by an internal epithelial layer, which together constitute the fundamental parts of the glandular organ. After the vascular trunks of the foetal or absorbent portion of the placenta become enveloped by the serotina, here changed into fibrous tissue, numerous chorial villi depart from them, pushing before themselves, while increasing in volume, the walls of the serotina transformed into a glandular secreting organ, ensheathing themselves, as it were, until they become completely clothed with it, like the fingers of a hand in a glove.

In the human species the utero-placental arteries and veins are not divided into trunks and branches but the maternal blood is poured out into cavities or sinuses circumscribed by the fibrous tissue of the serotina. In this way the blood of the mother bathes directly the exterior wall of the glandular organ furnishing an abundant supply of material from which the cells elaborate a secretion absorbed by the villi of the chorion.

To sum up then as plain as possible.

1. The placenta consists of two portions, the maternal and the foetal.
2. The maternal portion is a true glandular organ of new formation possessing the property, by means of its glandular elements, of secreting a fluid analogous to milk.*

*Ercolani gives the following as the results of the chemical analyses of Prévost and Morin, and Dr. Arthur Gamger.

Prévost and Morin out of 100 parts of fluid from the cotyledons of the cow.

Water.....	86.837
Solid parts.....	13.163
Albumen and fibrous substances.....	11.028
Gelatinous matter.....	0.516
Fat.....	0.750
Osmazone.....	0.714
Traces of salts.....	0.714

3. That this portion is always of new formation being developed by rapid changes in the cells of the decidua serotina.

4. That the foetal portion of the placenta is formed by the distribution of the villi of the chorion and these villi (resembling closely in form the villi of the intestine, in that they have a capillary artery and vein enclosed in a stroma of fibrous and epithelial tissue) penetrate into the glandular organ and there absorb the secretion and convey it to the foetus in a mode analogous to that in which the products of digestion are conveyed to the blood, thus furnishing the child in utero with means of nourishment.

IRREGULAR CONTRACTION OF THE UTERUS.

BY E. S. M'KEE, M. D., Cincinnati, Ohio.

The old time-honored term, "Hour-Glass Contraction," has been held in contempt by some of the brilliant ones of the later school. Hence, I, to escape possible criticism, christen my article with the name it bears.

Irregular contraction of the uterus, of course, is a more general term and applies more exactly to a larger number of varieties, and bids fair yet to obtain the position of title to this accident. Yet there are undoubtedly irregular contractions of the uterus which might well be termed Hour-Glass Contraction.

Looking into the matter more closely, we find the following: *Varieties*—A spasmodic contraction of (*a*) the os

Gamger out of 1,000 parts of fluid. Alkaline reaction. Specific gravity, 1.033. Fahr. 60°.

Water.....	879.10
Solid parts.....	120.90
Albumen.....	104.00
Alkaline albuminates.....	1.60
Fat.....	12.33
Inorganic salts.....	3.74

tincæ; (b) of its internal orifice; (c) of one or more portions of the body of the uterus; (d) of the whole body of the womb.

On account of the flaccidity of the cervix uteri, after the birth of the child, the presence of the contraction at the os tincæ is denied. It is also claimed that did this occur the contraction would be of short duration.

M. Gullimot says that the second variety is the true Hour-Glass Contraction.

As for the third variety, it is claimed that the uterus contracts accurately upon a body within its cavity, hence on the placenta. This variety may be partial or complete.

Stolz has written up the fourth variety, which is fully explained by the name given to it.

Frequency. Sixty-six cases of retention of the placenta, requiring the introduction of the hand, are reported by Collins as occurring in the Rotunda Hospital, in Dublin.

"In almost every instance this contraction took place where there was flooding. He scarcely ever introduced his hand into the uterus without meeting with it, whether the placenta had or had not been expelled."—*Burns*.

"In all my practice, consisting of upward of 1,200 cases, I have never met with a case resembling Hour-Glass Contraction. I have been called several times by my professional brethren when the placenta has been incarcerated in the uterus and the os closed."—*Robertson*.

"I never met with an Hour-Glass Contraction and think it very rare, or does not exist at all."—*Campbell*.

"Abnormal Adhesions and Hour-Glass Contractions are more frequently encountered in the experience of the young practitioner, and they diminish in frequency in direct ratio to increasing years."—*Braun*.

Although the post-partum Hour-Glass Contraction is so rare as to be entirely denied by some, the ante-partum variety is even much more rare.

Etiology. The use of the cord as a bell-rope or fishing

line, with which to draw out the placenta. The introduction of the hands or instruments of the accoucheur may result in the same condition. Especially is this the fact if the hands or instruments be cold. Any other irritation of the uterine muscles may result in the same. From the data in our possession we are brought to the conclusion that a disproportion between the presenting part of the child and the pelvis of the mother must be a cause. Among the other causes we have sudden emptying of the uterus, as in precipitate labor; after tedious labor, the uterus being exhausted and incapable of regular contraction; subsequent to the improper use of ergot; after the birth of twins, or where there was present a large amount of liquor amnii, or great distension of the uterus; premature evacuation of the liquor amnii.

Diagnosis. The placenta not coming down as it should after the delivery of the child, if traction on the cord is employed it is found that it does not descend, but instead it lengthens from elasticity, immediately retracting on release. This shows that it is attached above. Should the examiner pass his hand along the cord he will, in the true hour-glass contraction, find the external os patulous and flaccid, often distorted, readily admitting the finger up to the internal os. Here he meets an obstruction complete or nearly so to further progress. One finds a large or small portion of the placenta below the constriction, or it can be felt by the finger-tip above the stricture. Internally one finds those parts of the uterus above the constriction hard and firm. This can also be felt externally, and the constricting band can in many instances be made out. The uterus is found high up in the pelvic cavity and elongated with its transverse diameter diminished.

The writer would urge upon the profession the importance of abdominal palpation as an additional means of diagnosis. An expert diagnostician should be able to make

out the presence of hour-glass contraction through the abnormal walls.

Prognosis. In this statistics do not come much to our aid, and we do not know a great deal concerning it.

Treatment. Remove, first, the spasmodic contraction, then remove the placenta if retained. Time alone will sometimes remove the constriction, though it may permit of its increase. There being no contra-indicating implications as hæmorrhage or lapse of time, one may quietly wait. Six or eight hours having passed by it is better to commence active measures. One may try to dilate the constricted orifice by inserting two fingers, and by firm, steady, and continued, yet slight force, overcome the spasm, or, as it were, wear it out. As a preparatory measure, the fingers should be smeared with unguentum belladonnæ. King asserts that it is not affected by anæsthetics. Opiates, decoctions of belladonna and hyoscyamus are recommended. Frankel recommends subcutaneous injection of morphia muriate, 0.015 0.003 gram.; atropiæ sulph., 1 milligram. Dr. Richardson recommends amyl nitrite, gtt. iij., ether 3 j.; inhale. Dr. Fancourt Barnes recommends inhalations of three drops of nitrite of amyl on a handkerchief. Johnson has had excellent results with hypodermic injections of belladonna. Warm fomentations and irritations to the abdomen, sinapisms, turpentine stupes to hypogastric region, venesection when patient is plethoric, and warm baths. In the ante-partal variety, the upright position has been found to be favorable to delivery. Ramsbotham objects to large doses of opium. They may, he says, so paralyze the uterus that it will not again contract. Warm baths might produce hæmorrhage, which might not be easily detected.

If a small portion of the placenta is found to be below the constriction, it should be pushed up and the hand made to penetrate into the uterine cavity. If strangulated near the middle, one should pass the hand up and secure the

part above. If the major portion is below the constriction this should be compressed, thus lessening that above and favoring delivery. Do not, however, be too eager to remove every bit. The dangers of allowing a portion of the placenta to remain are great; those of forcible detachment are greater. When it is difficult to induce the dilatation of the stricture, M. Dubroca, of Bordeaux, introduces one finger into the placenta, tearing it up and reducing it to fragments, which are afterward expelled. He has found this plan useful in cases in which he could not introduce the hand. One may inject cold water into the placenta, through the umbilical vein, with considerable force. This should be retained a few minutes by compressing the cord, then released, and the injection repeated. This has an effect both on the placenta and the uterus. If everything else fails, incisions through the stricture should be made. Care should be taken that the cut is made sufficiently deep. It should be made with the long blunt fistula shears. The following rules are given as to prophylactics: (A.) Avoid every cause liable to irritate the uterus. (B.) When antepartal, avoid a too early rupture of the membrane. (C.) As far as possible remove all impediments to the expulsion of the child from the uterus. (D.) Assist with the forceps or by turning before the cervix becomes excessive.

THE VECTIS, AND MACROTIN.

BY W. E. ROGERS, M. D., Rexford Flats, N. Y.

From the *Albany Medical Annals*.—I was instructed in the medical school never to take an instrument with me to the bedside of the patient. I have long since learned never to go there without one.

The vectis is my favorite instrument, and I seldom find it necessary to resort to the forceps. Many times when the

pains were good, but when the head, though properly presenting, was not in just the position to glide along the oblique diameter of the pelvis easily, and the labor was thus retarded, I have, by slipping the vectis under that side of the head which was unduly pressing against the pelvis, lifted it into its proper place, and then, with a little traction, brought about the delivery speedily.

When the pains are inefficient and the os undilated and unyielding, I put five or six grains of *Macrotin* in half a teacupful of water, and give, every fifteen minutes, one or two teaspoonfuls. One of the first effects observed is a relaxation of the os and soft parts and an increased flow of mucous. The pains now soon improve, you slip in the little vectis, and when the uterus pushes, you pull, and in an incredibly short time the labor is accomplished *cito, tuto et jucunde*.

DELIVERY OF THE HEAD IN THE SECOND STAGE OF LABOR.

BY JAMES D. MCGAUGHEY, M. D., Wallingford, Conn.

(1). Both hands can be used. (2). The function of the right hand is principally that of a sentry to watch over the perineum, the advance of the head and uterine force. (3). It can, if necessary, be used to dilate the maternal passage, stretch the perineum, or be introduced into the rectum, when feasible, to hook up the chin. (4). The fingers of the hand can be brought to bear at the fourchette to meet those of the left hand from above, to fortify and strengthen this thinned and weakened part. (5). The right hand can be used to counteract too much pressure downward against the rectum, or can be used to fulfil the indications laid down by Playfair. (6). The position of the patient and the position of the accoucheur enables him to watch the advance of the head and the action of the perineum under pain. (7).

The left hand fulfils those most important indications laid down by Barnes, Lusk, Goodell and others, to support the head. It has great power to repel or direct the foetal head. It protects the thinned edge of the perineum, the fourchette, the *external structural end* of the posterior curved surface of the parturient canal, and directs the head and shoulders from this point in the imaginary line, the curve of Carus, over the symphysis pubis, carrying out the external mechanism of labor perfectly. (9) If laceration cannot be prevented, it can be limited in depth. (10). While the left hand directs the head, the right can look after the shoulders. (11). The child's head having been born under the eye, the extent, externally, of laceration can be seen, and will give a correct idea of its actual depth. Sometimes mistakes are made as to actual depth and extent of perineal wounds, on account of the thorough relaxation and retraction of the perineum after the complete delivery of the child. (12) In thinned and livid perineum, where the utmost tension has been reached and laceration about to occur, the head can be repelled, and episiotomy can be easily performed, with the scissors in the right hand. (13). With proper attention to details suited to each individual case, with perseverance and patience, it is my belief that more laceration can be prevented in the management of the second stage of labor by the method described, with its details, than by any other. There is one precaution to be observed. When the head is well engaged between the labia, and the pains are strong and forcible, and the chin is about to clear the perineum, the physician, in his eagerness to prevent a laceration, is apt, with the left hand placed in the position I have described, to exert too much force to keep the sub-occipital point hugging the under surface of the pubis, and might produce a laceration of the sub-urethral surface, or a solution of its continuity.

OUR LONDON LETTER.

(From our special correspondent.)

LONDON METHODS.

Though in some things our English cousins are slow to follow the world with readiness to grasp new ways, we can not say that they are behind, in adopting and recognizing improved operative methods, in the surgical treatment of disease. The wide field presented by the London hospitals, for scientific research and demonstration, becomes a source of the perfection of methods and of due consideration of new suggestions. Of course we see each surgeon, according to his experience or particular line of thought, pursuing such a course as is most suitable to the case he may have under consideration; but with all this there is a unity of action, which discussion, and especially that by the International Medical Congress, has been instrumental in establishing.

In amputation of the cervix Dr. Richard Smith has been very successful; his method is to use the *eccraseur* with a smooth wire. After the snare of the wire has been adjusted to the cervix, a very slow tightening of the loop is insisted upon, as avoiding hæmorrhage and resultant inflammation of the surrounding tissues. This process completed, the speculum is introduced and the crushed surface converted into a mass of charred tissue by the cautery at a *white heat*. The vagina is packed with a dressing of *plegets* of absorbant cotton; the first piece impacted against the charred surface being soaked in carbolized oil. Rectal suppositories of opium are used to relieve pain after the operation.

For the removal of mucous polypi from the uterine cavity, the same operator, at Soho Square Hospital, dilates the cervix by a series of hard rubber dilators. These are about eight inches long, slightly curved, and of uniform size, except at the uterine extremity, which tapers to a blunt point, and the handle resembling that of the ordinary

sound. This method of dilatation requires considerable time, nearly ten minutes being taken for a dilatation sufficient to admit a curette. After the growths have been removed by the curette the uterine cavity is cauterized by the use of a pencil of nitrate of silver. To complete the operation an iodoform bougie of twelve grains strength is introduced into the cavity of the uterus and the dressing of absorbant cotton applied.

In laporatomy the treatment of the pedicle is the most interesting feature of the operation. Nearly all here claim that ligature with silk floss, before dropping the pedicle back into the pelvic cavity, gives the best results. In conversation with Lawson Tait, one of the "shining lights" in ovarion diseases, he says that although Baker Brown's method of treatment of the pedicle with the cautery has succeeded well, it takes too much of the operator's valuable time, so that he gives preference to the silk ligature, using it exclusively, as giving no trouble in the production of septicemic symptoms after the wound has closed up. The sutures in the abdominal incision are either cat-gut or silk-worm gut. At Soho Square all antiseptic precautions are used. The carbolized spray is allowed to play directly on the abdomen. Carbolized water is used to moisten the hands of the operator and his assistants and all instruments, ligatures and sutures are kept in shallow basins of carbolized water when not in use.

The opinion here seems to be rather tending towards maintaining the right of the general surgeon to perform such operations as ovariectomy, some regarding an uncomplicated case of ovariectomy as one of the easiest operations in surgery. But since success depends on attention to details and a readiness to overcome any condition that may be encountered, it seems, apart from the question of diagnosis, that the specialist who devotes his time to abdominal surgery will be better prepared to meet such contingencies.

LONDON, Feb. 16, 1885.

H. H. C.

ABSTRACTS.

DRESSING OF NEW-BORN INFANTS.—For the benefit of the much-abused baby we give an abstract from a paper read by Dr. P. H. Wright before the Macon, Ga., Medical Society:

This is a trite and old-time subject, but one which, although much talked of by old grannies and anxious mothers, doubtless, since the time of Mother Eve, has not I fear, received that attention its importance demands from the profession. Medical men, and even our standard works on obstetrics, do not give the subject that attention its importance demands. We have too much left this very important part of our duties in the lying-in chamber in the hands of ignorant nurses, who too often think they know better how to dress and take care of the baby than the physician.

In my own experience, I have found the following method gives the most comfort to all hands, by giving the the baby no excuse for those cries, which are seldom heard, if the baby is not uncomfortable:

1st. As a rule, especially in cold weather, the baby should not be bathed for several hours—twelve, or better still, twenty-four.

This rule I have sometimes found it hard to enforce, for the reason that the women are very particular that the babe should be washed clean as quickly as possible. But it is *important*, and should be insisted on, when we consider the great difference in the temperature of the mother's womb and the atmosphere outside, as well as the suddenness of the change, we can readily understand how easy it is for the young child to become chilled, thereby exposing it to disease.

In my opinion this practice of washing and dressing the babe so soon as it is born is one of the most fruitful sources of influenza, nasal catarrh, etc.

2. The child should be warmly and comfortably dressed, with easy, loose-fitting garments suspended from the shoulders (flannel next to the skin), being careful to allow no constriction at any part of the body. As to the dressing of the cord, I have for a long time been in the habit of simply enveloping the cord with raw, clean cotton, wrapping it snugly around the cord. This is usually all the dressing it will need, and in a few days the cord will come off without causing any discomfort.

The belly-band should only be put on just snugly enough to keep the cord secured from falling about, but not in the least to impede the free expansion of the abdominal walls.

If we should give this seemingly unimportant subject more of our personal attention, and see to it that so far as the first dressing and other management of the young child is concerned, it is properly done, we would save many babes from much discomfort, if not, as I believe, frequently from serious disease.—*Atlanta Med. Journal*.

The *Medical Record* gives the following important points from a paper on "The Experimental and Clinical Study of Air Embolism," read before the American Surgical Association, by Dr. N. Senn of Milwaukee, Wis.

1. The presence of adventitious air in the vascular system during life gives rise to air embolism.

2. Each air-embolus constitutes a mechanical source of partial or complete obstruction to the flow of blood in the vessel in which it is located.

3. Aspiration during the inspiratory movements of the chest is the direct or exciting cause of the ingress of air into a wounded vein or sinus.

4. Elevation of the head is the sole predisposing cause of the entrance of air in wounds of the superior longitudinal sinus.

5. In veins the predisposing causes consist in (a) ele-

vation of the part wounded; (b) pathological or anatomical conditions which prevent collapse of the vein when it is wounded.

6. Insufflation of a fatal quantity of air into a vein produces death by (a) mechanical over-distention of the right ventricle of the heart and paralysis of the diastole; (b) asphyxia from obstruction to the pulmonary circulation consequent upon embolism of the pulmonary artery.

7. Insufflation of the same quantity of air into arteries is less dangerous than when introduced into veins. When death is produced in this manner, it results from (a) acute cerebral ischæmia; (b) secondary venous air embolism; (c) intense collateral engorgement of the vessels of the brain and spinal cord, the manner of death being determined by the amount of air injected and the direction in which the injection is thrown, as well as the time which has elapsed between the operation and the fatal termination.

8. Air injected into arteries is readily forced through the systemic capillaries into the venous circulation and right side of the heart by the powerful contractions of the left ventricle.

9. An air embolus of the pulmonary artery is relieved in a comparatively short time, provided the contractions of the right ventricle continue unimpaired for a sufficient length of time to force the air through the pulmonary capillaries into the general circulation.

10. The prophylactic treatment consists in proximal or double compression or ligation of the vein which is endangered by the operation.

11. The indirect treatment has for its objects (a) prevention of the admission of air; (b) administration by inhalation or hypodermatic injection of cardiac stimulants; (c) venesection.

12. The direct or operative treatment by (a) puncture and aspiration of the right ventricle; (b) catheterization and aspiration of right auricle, which is proposed to ob-

viate the direct cause of death by the removal of air and spumous blood, thus relieving directly the over-distention of the right ventricle, and at the same time to guard against a fatal embolism of the pulmonary artery.

13. The results obtained by experiments on animals warrant the adoption of the operative treatment of air embolism in practice, as a last resort, in all cases where the indirect treatment has proved inadequate to meet the urgent indications.

CÆSARIAN SECTION.—The interest manifested in the discussion of Cæsarian section at present, affords an excuse for the publication of the following almost incredible case of self-delivery by laparotomy, as reported by a German cotemporary:

One of the strangest cases, perhaps, on record in the annals of gynæcological practice, was reported by Dr. Guggenberg at the meeting of German physicians in Tetschen, Bohemia—the case of a confined woman performing laparotomy successfully on herself, the woman herself in perfect health being presented to the society. At two o'clock, as Dr. G. related, he was summoned to hurry to a woman who had cut her abdomen open. He found a woman of large and strong build, but of a thoroughly anæmic type, on a poorly-furnished bed, surrounded by unmistakable evidences of poverty. Examination of her eyes, which were lightly closed, revealed that her pupils reacted promptly to light and shadow; her pulse was scarcely perceptible; her consciousness, though not perfectly intact, was sufficiently clear to enable her to answer questions put to her by corresponding motions of her head. Examination of her body showed an incised abdominal wound running from above downward and inward, exposing a considerable quantity of intestines. The uterus was seen below, firmly contracted, of about the size of a child's head; bleeding had stopped altogether. Between her knees he discovered a dead child.

The parts having been carefully cleansed and the intestines replaced, the wound was sewed up and dressed antiseptically. Besides vomiting and moderate fever for a few days, no unfavorable symptoms appeared. The history of this case showed that the woman had seven previous confinements, all more or less of a severe type. This time the labor-pains had been so intense that the woman felt convinced that she had to die; and having heard or read of the Cæsarean section, she decided to perform it on herself, with the hope of thus gaining an easier death. She divided layer after layer, until a profuse hæmorrhage arrested her operation. A dark protruding mass was taken up, recognized as the afterbirth, and placed under the bed; finally a foot appeared, on which she dragged until the whole body had been drawn through the external wound. Having cut the cord, the woman lay down to die, but was shortly after discovered by her relatives in her precarious condition. She recovered completely, and is capable of performing the hardest kind of work.—*Wien. Med. Bl.*, Jan. 15, 1885.

A REMEDY FOR ENDOCERVICITIS.—Dr. J. C. Shirk writes in *The Practitioner*: "There is one condition of the cervix uteri which resists all ordinary methods of treatment. I refer to that obstinate form of endocervicitis, in which a discharge quite similar to the white of an egg is poured out in great quantities. In all forms of cervical catarrh this secretion is produced more or less, but in the form I refer to the glands are remarkably active and produce immense quantities of this discharge. As said before, the ordinary forms of astringent and caustic applications will not cure this condition. I have found but one remedy that will cure these cases, namely, an aqueous solution of chromic acid (3 j. to aqua 3 j.). Four or five applications of this remedy at intervals of a week usually suffice." Another mode of treatment is to curette the glands.—*Med. Record*. [In reference to the above or any abstract on this

subject, the editor simply desires to add, by way of an opinion, relative to the treatment of endocervicitis, that "you pays your money and you takes your choice."

DRAMATIS PERSONÆ.—Gynæcologist and patient who had married a widower with several children, one of whom was in the waiting-room. Gynæcologist, looking through the speculum—"How many children have you?" Patient—"We have four in the family, doctor." Ah! four children. That explains the condition of your cervix, madam. It was badly lacerated at your last confinement, and can only be relieved by trachelorrhaphy." But, doctor, ain't you mistaken? I—"Mistaken, madam! impossible. I tell you, you have laceration of the cervix, dating from your last confinement." "But, doctor—" "Now, madam, I know what is the matter with you, and it's no use for you to volunteer any further information. You must submit to an operation." "But, doctor, I *will* speak. I never had a child. The children we have are my husband's, by a former marriage." Tableau.—*Med. Age*.

WHERE WE TASTE THE DISGUSTING.—The third and lowest part of the tongue, supplied by the glosso-pharyngeal and throat, is the seat of those peculiar tastes to which was given the names of relish and disgust. It is here chiefly that we taste animal food, fats, butters, oils, and the richer class of vegetables and made dishes. If we like them, we experience a sensation which may be called a relish, and which induces one to keep rolling the morsel further down the throat till it passes at last beyond the region of our voluntary control. If we don't like them, we get the sensation which may be called a disgust.—*Med. Record*.

The *Atlanta Medical and Surgical Journal* quotes from the *Examiner* the following rather good story of a physi-

cian of Dayton, O.: The doctor was recently attending a case of labor in the family of one of his patrons, who, though a very excellent man, is a little slow in the payment of his medical bills. Immediately after the birth of the child, the father nervously asked: "Doctor, is the baby marked?" "Yes," quietly remarked the doctor, "it is marked 'C. O. D.!' " The bill for that baby was promptly settled.

NEW PUBLICATIONS.

AN INTRODUCTION TO THE STUDY OF THE DISEASES OF THE NERVOUS SYSTEM. By Thomas Grainger Stewart, M. D., Edinburgh. Bell & Bradfute, 12 Bank Street.

This book contains the lectures delivered in the University of Edinburgh. The first three chapters present the anatomy of the nervous system, comprising the important facts that are necessary to an understanding of the general considerations of nervous diseases. The lectures from the fourth to the twelfth constitute a commentary upon and illustrations of the method of examination and describing nervous symptoms; while the last two give a general consideration of the pathology and treatment. The author falls into error in bringing the investigation of nervous diseases into so small a space, by trying to give a general description; the points touched upon are so widely scattered that on finishing the book it conveys an idea of nervous *symptoms* but not of the *diagnosis* of nervous diseases. We can especially commend the form of the clinical record for taking cases, the illustrations and the chapter on medical electricity.

BEFORE I BEGAN TO SPEAK. By a Baby. Printed and published at the Fleet Printing Works, 14 Whitefriars, London, E. C. 1885.

This pamphlet contains an earnest pleading for "the most helpless class in creation," and sets forth a tale of the discomforts, troubles, and sufferings babies endure; in fact, to which, many times through thoughtlessness, they are continually subjected. It is worthy of a place in advice given to young mothers, and even the physician may find some few hints as to the necessity of regulating the surroundings of a nursery.

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HINTS ON THE THIRD STAGE OF LABOR.

Especially as this concerns the evacuation of uterus.

J. C. SANDERS, M. D., Cleveland, O.

The forces concerned in the accomplishment of the third stage of labor are for the most part, the same as those by which labor in the second stage is effected, though less pronounced and somewhat varied in their relative proportion. They are classified thus:

(a.) The involuntary forces. (b.) The voluntary forces.

(a.) The involuntary forces are subdivided into two orders: 1st. The tonic force. 2nd. The clonic forces.

1st. The tonic force. This is the force exerted by the steady and continuous contraction of all the contractile structures concerned in labor in this stage, viz.: the uterine fibers and the uterine ligaments, and, soon as the placenta enters the vagina, the muscular walls of the vagina con-

joined with those of the perinæum. This is that steady and firm force that, after the expulsion of the child, condenses and compresses the uterus down upon and around the placenta, and, after the placenta has been cleaved off from its attachment, helps expel and force it down into the vagina, closes up the sinuses and orifices laid open and made patulous by its detachment and extrusion, and, continuing to condense and ensmall the uterus, protects against hæmorrhage and inversion, and contributes largely to the process of involution. These are exclusively the province of the tonic forces of the uterine structures. This force as the vaginal and perinæal structures exercise it, acts upon the placental mass in the same way as the uterus acts upon it, though with much less promptness and efficiency. This force as exerted by the vaginal and perinæal structures, though slight and tardy as compared with that of the uterine fibres, is considerable, and were time sufficient given, would probably suffice alone in the majority of cases to compel the completion of the placenta's extrusion.

2nd. The clonic forces. These are the paroxysmal forces—or the forces of the pains so called—exerted by the uterus after the expulsion of the child, upon the placenta for its detachment and expulsion out of the uterus. The province of this force is exhausted when the placenta has been detached and expelled from the uterus, whether still in the vagina or not, except as these forces may become again challenged by the immediate or subsequent accumulation of blood clotted or not within the uterus, from a partial failure and relaxation of its tonic force. These forces can have no influence whatever in the extrusion of the placenta from the vagina, except when the uterus is low down within the vagina, as it sometimes is, even touching the floor of the perinæum. With this exception out, so far as these forces can exert any influence upon the delivery of the placenta, they are limited to the placenta's detachment and extrusion from the uterus.

There is a clonic force exerted by the vaginal and perinæal structures, slight it is true, but unquestioned, similar to the involuntary tenesmic action of the rectum and bladder, that contributes something and quite a moiety of power, in the expulsion of the placenta from the vagina.

(b.) The voluntary forces. These are that aggregate force exerted by the fixed diaphragm and the retracted abdominal muscles upon the uterus, now emptied of the child and riding still as an abdominal viscus above the brim of the pelvis, and is exerted coincident with the clonic contraction of the uterus. So far as its influence upon the uterus is concerned this force is inconsiderable, on account of the callapsed condition of the abdominal muscles. It may be said to be limited to rendering some help in the expulsion of the placenta from the uterus but is incapable of rendering any special aid in its detachment. But when the placental mass has passed down into the vagina, this force becomes quite efficient, and aidful in the completion of the placenta's extrusion. The fixed diaphragm, the fixed and retracted abdominal front crowds the now emptied uterus down somewhat within the brim and against the placental mass, and thus acts mechanically, to press it down and out from the vagina. The natural forces here exercised, however, are made up of three factors, viz.; one is the mechanical pressure, exerted from above through the uterus, another is the clonic tenesmic action of the vaginal and perinæal structures, and the third is the tonic force exerted by these last named structures. There is, however, another force possible here, but possible only to a sitting or upright posture, the force of the gravity of the placenta.

From these individualizations it is clearly evident that there has been assigned, in the economy of nature, a distinctively chief office to the varied forces concerned in the process of labor in the third stage, and indeed, this is true in other stages. These may be summarized as follows:

- 1st. The condensation of the uterine walls and the

permanent ensmallment of the uterine cavity after it has been emptied of its contents, devolve chiefly on the tonic force of the uterine contractile structures.

2nd. The detachment of the placenta and its extrusion from the uterine cavity devolve chiefly on the clonic forces, the pains, so called, of the uterus.

3d. The extrusion of the placenta from the vagina devolves chiefly on the voluntary forces.

These then are the sum of all the forces and the special, predominant province of each, which nature has provided and on which she relies for the fulfilment of labor in this stage. Had they not, in her allwise economy, been esteemed sufficient, doubtless she would have supplemented such deficiency by providing other sources of help and rescue. As she has not, however, is she not to be trusted in her reliance on these alone? Is she not to be given a fair and reasonable opportunity for the free and full exercise of these forces? We trust her in the two stages of labor that precede, in the first stage and in the second stage. Why not in the third? In those labors in which she is esteemed and proves herself unaidedly adequate for the accomplishment of the first and second stages, shall she not be esteemed and trusted as presumably adequate for the unaided accomplishment of the third stage? When we trust her in the first and second stages, why not in the third? Why not give her opportunity for the amplest exercise of the forces she has provided for the accomplishment of this stage? But what are we to understand by this opportunity, this privilege that should be given to the forces so amply provided? Simply this, *time, a reasonable time, for their activity!* But what is a reasonable time? A reasonable time is by no means an arbitrary cycle of minutes, a fixed and uniform measure of time, adopted to every case, for it is self evident that each case must have its own measure of time that reasonably can be granted to these forces. But let us draw nearer yet to the idea we

are seeking to solve. It is conceded that the pains of the third stage copy more closely the pains of the first stage than those of the second stage, by their widened intervals, by their lessened severity or intensity, by their demoralization of the patient's courage and faith. What is the average intervals of the pains of the first stage? We answer, from five to thirty minutes, and this too, when the uterus is in full possession of its energies. What then rationally can be expected of the first interval that follows the close of the second stage, after the uterus has struggled in active and often furious labor for twelve, eighteen or even twenty-four hours or more, other than that this first interval should be somewhat protracted beyond the average duration of the intervals of the first stage! Even to twenty minutes or thirty minutes or more! And what are the number of pains ordinarily required to separate and expel the placenta from the uterus? We answer, from three to five, rarely less than three, and rarely more than five. Now grant the minimum, say three pains, with minimum five minute intervals, though the intervals that succeed the first interval, are more often longer than this, and what is our result? We have fifteen minutes consumed in even the three pains, but often more, which with the first interval of fifteen to thirty minutes give an average aggregate to this stage of from thirty to sixty minutes! In case the uterine ganglionic powers have been especially taxed by a severe or protracted labor, or the general nerve centres or even the muscular spheres have been put to a great expenditure of energy, those intervals, not alone the first, but those that succeed, will and must, in the nature of things, become extended beyond the average standard, and the duration of this stage be correspondingly lengthened. How frequent are the cases where the uterine and general nerve shock is such that a uterine contraction other than tonic does not ensue for a full half hour or even longer, and will not and can not ensue until the uterine ganglia and the other nerve

centres have had time to rally and recover from their depression.

There are three unquestionable and undeniable corollary propositions derivable from this brief discussion, indeed they are axiomatic and require neither vindication nor defense.

1st. Nature as a rule is presumably adequate for the unaided accomplishment of the third stage of labor, so far surely as the emptying of the uterus is concerned.

2nd. A reasonable opportunity should be given to her, for its unaided fulfilment.

3rd. The proper province of obstetric art in this stage is limited to supplement what the natural powers fail to do, or give evidence, after a reasonable opportunity has been granted, of a disqualification to do, for its safe accomplishment.

In the face of these propositions how strange are the teachings on this subject of the recognized modern authorities in both schools.

Fleishman, referring to Credi's method, says: "In this way a very few minutes will generally suffice for the passage of the placenta."

Playfair cautions against undue haste, yet referring to McClintock, who lays down the rule that fifteen to twenty minutes should be allowed to elapse before any attempt to remove the after birth is made, says: "This is a good and safe practical rule, as it gives ample time for the complete detachment of the placenta and the coagulation of the blood in the uterine sinuses. Again he says: "Generally speaking the placenta should be expelled within twenty minutes after the birth of the child, but no doubt in the large majority of cases, expulsion might be effected sooner, were it advisable to attempt it."

Richardson quotes and adopts Playfair's proposition of delivery by art *a la Credi*, and the fifteen to twenty minutes limitation of McClintock's rule.

Leavitt says: "The most approved way seems to be for the physician to place his hand over the fundus exerting only sufficient pressure to maintain uterine contraction and guard against hemorrhage, moving the hand about from time to time in gentle friction until uterine action is excited, when he should make firm and equable pressure in a direction downward and backward until extrusion at least into the vagina is effected. If the first strong effort is unsuccessful it should be repeated during the succeeding uterine contraction."

Guernsey says: "In most cases there is a momentary cessation of pain immediately after the expulsion of the child, upon which the pains return in a diminished degree and the placenta usually becomes entirely detached from its uterine connection and either lies free in the vagina or is expelled without the vulva. It often happens the detachment of the placenta and its extrusion into the vagina follows immediately after the expulsion of the child. Should the placenta be found to be still attached to the uterus after a delay of about twenty minutes, proper remedies should be administered to promote the expulsion of the placenta. This may be aided by applying the palm of the hand to the abdomen immediately over the fundus uteri and making gentle pressure upon that organ as though attempting to clasp it."

Lusk says: "It is true that the expulsion of the placenta will as a rule occur spontaneously." But he is silent as to the obstetric duty under this rule, silent as to whether nature is to be given any time or opportunity for the spontaneous act, conceded to be competent for the fulfillment of this stage.

Neither by Lusk nor by any one of the other authorities quoted, and they are all standard, is there a concession of a varying grade of time,—time for the uterus to recover from weariness or shock, time for the general nerve centres and muscular sphere to rally, time for the first interval,

time for the required pains to effect detachment, or time for their respective intervals, but all seem bound by the tyranny of this McClintock rule of twenty minutes limitation, and when this measure of delay has been meted out by the watch's or clock's remorseless tick, the attack must begin and one or another of the various devices of interference must be put into active and persistent efficiency until extrusion of the placenta has been accomplished.

The object of this paper is, (1), an earnest protest against this arbitrary and austere rule, that in its practical results overrides and contravenes the whole philosophy of placental delivery. (2.) Our humble plea for a practical, recognition of nature's own competency, as a rule, successfully to accomplish unaided the delicate function of placental delivery. (3.) An encouragement of such a trust and faith in her competency, as will protect her against impatient, hasty, obtrusive officiousness in the name and under the mask of obstetric art. The province of art is always most exalted whenever it approaches nature most closely, whenever it so imitates her as to take her likeness and reveal her spirit and intent. Whenever nature is adequate, successfully and safely to carry on and complete the function of labor in either stage, obstetric art should be silent but watchful, instant but restrained. This entire discussion is exclusive of the duties that pertain to this stage from the time and after the placenta as a whole, or for the most part, occupies the vagina; for when here as a general statement, it is a dangerous presence and unless at once removed by the natural forces, art should come to the rescue and promptly secure its delivery.

OVARIOTOMY.*

PHIL PORTER, M. D., Detroit, Mich.

Without attempting to go into the history of this operation its rise and progress, we shall proceed at once to the consideration of the indications for operation.

Many ovariologists postpone operating until the growth has assumed a very large size, interfering with the normal function of the abdominal organs, and the patient becomes anæmic and a confirmed invalid. This we think a mistake, as in later years, antiseptic advantages, *strict cleanliness*, and proper *homœopathic* after treatment modify the views regarding the dangers from shock, peritonitis, hæmorrhage and other dreaded complications that formerly were expected.

We do not now approach an operation for the relief of an ovarian cyst with the dread we formerly did. In the last three years we have never administered one particle of morphia or opium in any form, relying upon *Hypericum* or the indicated remedy instead. It is simply astonishing to see how rapidly a case will progress to recovery after an ovariectomy, if the system be not compelled to labor under the deleterious effect of an opiate or sedative.

If we suspect the tumor to be malignant, an operation is advised at once, or if on tapping to settle a doubtful diagnosis, the growth is found colloid in structure, an early removal is also advised.

The *contra-indications* for an ovariectomy are quite as prominent as the indications *for* an operation. Cancerous conditions of an ovary, or of any abdominal organ, tuberculosis, advanced scrofula, all organic disease of the heart, brain, liver, or kidneys, disease of the alimentary canal, or extensive adhesions in the lower part of the tumor, should deter us from operating.

But such complications as ascites, debility, peritonitis,

*American Institute—Abstract of Papers; Bureau of Gynecology.

albuminuria, or a previous ovariectomy should not prevent our operating. The statistics of foreign ovariotomists give the mortality as less during the spring and summer months, than in the fall and winter, but though season would seem to influence by some exceptional and climatic change, yet we cannot but think that *personality* has more to do with an operator's results than the season.

Preparation of the patient:—In taking the necessary preparatory measures every case must be judged by its *own peculiarities*; not only those relating to physical conditions, but the various mental, moral and social influences, which must be considered constantly in private daily practice, and which so materially affect the results of any operation, should be also brought into as healthy and normal relations as possible. The patient must be put under healthy influences, with rest under the favorable conditions of a large airy room in a private house with proper hygienic surroundings and, if circumstances permit, with the attendance of a *trained nurse*.

The night before the operation the patient should have a warm bath, and the abdomen should be well cleansed. Nothing should be eaten from four to six hours before the operation. The bowels and bladder should be thoroughly evacuated. The temperature of the room should be raised to eighty degrees Fahrenheit, and maintained during the time that the abdominal cavity is exposed. The patients clothing should be protected from all discharges and water and the lower extremities covered by warm light blankets or flannel.

The necessary instruments for a simple case of ovariotomy are few; a scalpel, to divide the abdominal wall; a director, to protect the cyst, as this division is completed; a trocar, to empty the cyst; needles and silk to secure the pedicle and close the wound; with forceps and ligatures to secure any bleeding vessel, and cautery irons, complete the list.

To meet accidental emergencies, it is necessary to have a full supply of instruments.

The abdominal incision should be made through the *linea alba*, carefully separating the sheaths of the recti muscles, and the incision should be made so as to cautiously expose the peritoneum. Before opening the peritoneal cavity all bleeding points should be secured. On reaching the peritoneum it may be picked up with the forceps or tenaculum and "nicked" with the knife or scissors. This incision is continued with the peritoneal scalpel to the full extent of the incision in the skin. If on reaching the cyst it is found to have extensive adhesions it is better to empty it before attempting to separate from the surrounding tissues. If the adhesions are not extensive and the cyst has been clearly made out, they may be broken up by two fingers or by inserting the whole hand between the cyst and the abdominal wall. When the adhesions have been separated and the cyst is free the operator should select the most prominent part of the tumor and plunge the trocar well within the cavity. When the cyst has been reduced in size sufficiently to allow the tumor to pass through the abdominal opening, Nelaton's cyst forceps are placed over the puncture and the cyst drawn through the incision.

As the cyst is drawn out of the abdominal cavity, the intestines are protected by a large flat sponge about twelve inches square, wrung out of hot water, passed in and left between them and the abdominal wall. Having drawn out the cyst, separated the adhesions and secured any bleeding vessel, the next important step is to secure the pedicle.

Such a diversity of opinion prevails regarding the treatment of the pedicle that we shall only refer to our own method leaving a history of other operators to the complete paper.

After evacuating the cyst and applying the large clamp, we divided the pedicle fully one inch above the clamp and apply the cautery to the end of the stump. If after

the handle of the clamps have been loosened there is hæmorrhage we crowd the pedicle to the centre of the jaw of the clamps and again shut down with considerable force on the mass. After this the stump is slowly cooked with a hot iron, heating the clamps at the same time and with a second iron burn off the already cooked end down to the clamp. If the jaws of the clamp have been heated enough during the above process, a substance resembling cold glue will appear upon the surface of the stump as well as the serrated indentations of the edge of the clamp. The cooling of the clamp must be gradual and the pedicle secured, for later inspection, before it is dropped into the abdominal cavity. We, at first, added a ligature in cases of a broad or cedematous pedicle, but have now abandoned this practice.

The so-called "toilette" of the peritoneum is of much importance in relation to the success of the operation. Any fluid in the abdominal cavity must be carefully removed by sponges and should any oozing have followed the separation of adhesion the cavity may be flooded with water. It is seldom now that we are compelled to resort to this treatment.

For drainage, Keith's glass drainage tube is preferable.

In closing the abdominal incision as few sutures as possible should be employed and yet, secure coaptation of the peritoneum and abdominal walls. We usually employ two or three wire sutures, according to the length of the incision, with which the edges of the peritoneum are carefully and accurately brought together, to be secured later, with buckshot, over perforated lead shields, after the balance of the sutures have been introduced.

For the other sutures we employ silk worm gut; introducing them about an inch apart; passing them entirely through all the abdominal tissues including the peritoneum.

To the after treatment is due, in a large measure, the success of operators, employing homœopathic remedies *under the law of similars*. Do not prescribe remedies for

the after treatment of your case upon *the expectant or empirical* plan but according to *their indications* and so long as the mechanical part of the operation is performed correctly you may depend upon success. The surgical part is only a portion of this grand operation.

OVARIAN CYSTS.

L. A. PHILLIPS, M. D., Boston, Mass.

Among authorities on the origin and cause of ovarian cysts, there are many very different and conflicting opinions. Indeed it is conceded that what we know is entirely confined to the processes by which these causes produce their peculiar results, and the conclusions of pathologists and the opinion in regard to these processes are widely different and even antagonistic. Neither is there any general agreement as to the classification of growths or as to the application of terms; therefore we can but keep ourselves informed as to the various theories and await a final agreement which positive knowledge will afford.

To bring about a definite understanding, the term ovarian *cyst* and ovarian *cystoma* will be used here as synonymous, and applied to all growths from *within* the ovary which consist of a simple sac or sacs with fluid contents not however to tumors in which fluid may be incidentally developed, as in connection with carcinoma or sarcoma.

The various theories as to the pathology and origin of the ovarian cyst may be briefly stated as four: that advocated by Tait, that ovarian cysts develop from the Graaffian follicle from dropsical effusion or by abnormal secretion of its normal contents; the explanation offered by Waldeyer regarding proliferating cysts, that a cystoma originates not within the Graaffian follicle but from the more rudimentary forms of the epithelial portion of the ovary and from the tubular structures which have probably originated at the

embryonal period of the organ. Lucke claims that cysts may be generated by exudation into the new formed connective tissue, the fluid distending the different bundles; and the opinion of Noeggerath that proliferating cysts are developed from the tissues, composing the capillary blood vessels, which have become diseased. One fact is apparent in all these theories that these growths are all *epithelial products*.

The size of the ovarian cyst varies according to its stage of development and also as to its character and form. The multilocular tumors attain the greatest size.

As regards development the multilocular is also more rapid in growth. Statistics show that as a rule the average length of life, after development of these cysts, taking both together, is only about three years unless surgical aid is invoked.

The sac consists of three principal layers. The external and internal layers have the appearance of fibrous membrane while the middle layer seems to be loose cellular tissue.

Histologically the contents consist of epithelial cells, crystals of cholesterine, oil globules, granular cells, blood cells, and often pus cells. The symptoms of ovarian cystoma are mostly those due to mechanical pressure. When the cyst is small and confined to the pelvic cavity, the pressure may produce reflex nervous symptoms, vesical irritation, interference with defecation, oedema of lower limbs, or varices.

Later, as the tumor rises out of the pelvis and develops so as to fill the abdominal space, the signs of pressure will be manifested by the lungs and abdominal viscera, and as a result of this, general nutrition is impaired.

In the primary stage while the tumor is confined to the pelvis, digital examination will define a globular fluctuating mass lying behind or to one side of the uterus. By rectal examination, with a sound in the uterus, the tumor will be found movable more or less independantly of the uterus.

It can thus be distinguished from hæmatocele, cellulitis, retro-flexion, or uterine fibroid without much difficulty but not so easily from a cyst of the broad ligament, hydro-salpinx, or extra-uterine pregnancy. Generally the shape will distinguish between an ovarian cyst and a tubal cyst. Extra-uterine pregnancy is accompanied by an enlargement and softening of the womb and some times bloody discharge.

As regards development the multilocular cyst is also more rapid in growth. Statistics show that as a rule the average length of life, after development of these cysts, taking both together, is only about three years unless surgical aid is invoked.

The sac consists of three principal layers. The external and internal layers have the appearance of fibrous membrane, while the middle layers seem to be loose cellular tissue.

Covering the sac externally is the peritoneum which is easily separated, especially at the base. The internal surface is covered with epithelium which shows a variety of forms; in some parts normal, in others rapidly growing, immature cells.

The blood vessels, which are derived from the bulb of the ovary are distributed to the middle layer and between the fibrous layers. The nerves and lymphatics are distributed through the cyst wall. The contents vary greatly in appearance in different cysts. In color, from a light, colorless fluid, to a dark, or chocolate color. In consistency, from nearly that of water with a specific gravity of 1007 to a thick jelly.

The chemical constituents consist of organic substances, water, and salts of sodium and potassium. The point of practical value is that par albumen is present in ovarian fluid and not in ascites.

Diagnosis when the cyst has risen out of the pelvis is as a rule less difficult than before. Pregnancy should never be mistaken for an ovarian cyst, even if the uterus

can not be definitely outlined with bi-manual examination.

The condition of the cervix, the absence of any solid body within the cyst, absence of foetal heart sounds, absence of mammary changes, comparative thinness of the walls of the cyst and greater fluctuation should make it certain that pregnancy does not exist. Ascites is difficult to diagnose when the distension is great. If the patient be put upon her back with the thighs flexed to relieve muscular tension the abdomen will appear flattened and broadened in ascites, rounded and protruding in ovarian cyst. Dullness on percussion will change in location and be found at the most pendent portion of the abdomen.

Fibro-cystic tumors are of slow development, are intimately connected with the uterus, and the uterine cavity is generally enlarged. Cystic disease of other abdominal organs must be distinguished by chemical and microscopical test, if careful manual examination is insufficient. Between ovarian and parovarian cysts no very reliable diagnosis can be made unless by exploratory incision.

Exploratory incisions are condemned by some but I believe it will before long, be generally sanctioned and found superior to tapping.

In all cases of differential diagnosis an anæsthetic should be administered to enable a careful examiner to avoid mistaking other conditions for an ovarian cyst.

NEOPLASMS OF THE OVARY.

THEIR ÆTIOLOGY, PATHOLOGY AND PROPHYLAXIS.

O. S. RUNNELS, M. D., Indianapolis, Ind.

It has taken the human race ages to come to the recognition of the fatal truth that when nature goes wrong it is because some one has blundered, ignorantly or maliciously; and it may take other ages to secure the general application

of the proper remedy. There is too much living for self, regardless of consequences to those really most concerned, the penalty being visited on the weak rather than on the strong, who should bear it.

The vast range of our subject reaches to the very center of being, and embraces the life history of a human soul, its parental endowments, and its own acquirements. The question is: How can we change the startling statistical fact that more than three-quarters of all morbid growths that affect the race are uterine, ovarian, or mammary? The remedy is a thorough diffusion of the knowledge of the facts; (1), that the waters of the life-stream may run muddy for four generations, and during all this time deteriorations must cease, or perfect titles cannot be handed down; (2), parental indulgences must be curtailed; (3), the physiological bondage of stimulants, narcotics, or drugs of any kind must be shaken off; (4), the procreative function is for the reproduction of the species, and not for sexual gratification—and this indicates that the rights of the unborn created must be respected in the interests of all concerned; and (5), every one self-convicted, or who ought to be convicted, should take their bearings, make a new track, and study how they may join their powers to the great forces that make for righteousness, and but for which man would have perished long ago.

Nature's chief office is to build up, and a tendency to return to embryonic characters is a fundamental fact in disease. The life force tampered with results in neoplasms, and nowhere with such fantastic expression as in the ovarian region, where the memories of the race are stored for reproduction. Thus it is that the ovarian cyst is but a perverted graafian follicle, and every form of ovarian tumor but a developmental diversion of an embryonic capability. This is least epitomized in the dermoid cyst, where not only blood and bone, but teeth, hair, gland, muscle and nerve are produced.

It must be recognized by the people that the dominant influence is emitted from the ovaries, and that every organ and function of the woman's body pays tribute to their welfare. See that their nutrition be not unwittingly or purposely perverted or crippled, and the processes of disease and degeneration be thus established.

OOPHORITIS.

A. I. SAWYER, M. D., Monroe, Mich.

Inflammation of the ovaries may be acute or chronic. These may again be divided into primary, secondary, simple or compound. And still again divided into puerperal and non-puerperal.

Each of these varieties have stages of irritation, congestion and also often of suppuration. Congestion however of the ovaries may be normal as well as abnormal. There is a normal congestion at each menstrual period in a healthy woman, prior to the menopause when not pregnant, but should this congestion continue after the catamenial discharge it constitutes disease, in varied degrees of severity.

Simple, uncomplicated, acute, non-puerperal ovaritis, however is exceedingly rare, certainly unrecognized by the ordinary physician, except as the result of traumatism, and since puerperal ovaritis belongs to obstetrics, the field of observation is exceedingly small, consequently I have not attempted anything more than to adduce a few generalities and make certain deductions therefrom.

The concealed position of the ovaries, together with their intimate connections, associations and sympathies necessarily preclude a positive diagnosis except in the most obvious cases, for there is scarcely a symptom upon which you can rely except that of touch, while even that will mislead you. Inflammation of the uterus, broad

ligaments, pelvic, areolar and peritoneal tissues will often cause a train of symptoms, completely simulating those usually attributed to the more serious disease. Touch alone is of differential diagnostic value. If on conjoined manipulation you can seize, between your fingers, a small round body in Douglas' cul-de-sac or on the sides of the uterus, you may safely conclude that you have an ovary; and if this be found to be very sensitive to pressure, attended with nausea and vomiting, or hysterical symptoms, you may further conclude that you have an *inflamed ovary*.

The causes of ovaritis may be said to consist of anything that is capable of producing pelvic peritonitis, or peri-uterine cellulitis, including gonorrhœa, suppression of the menses, shocks and traumatism, hence ovaritis is rarely simple, but usually complex.

What has been said of acute will apply with equal force to chronic ovaritis except that the latter is much more common and much less amenable to treatment, than the former. That the chronic form is more common than the acute, is due to intimate relations of the pelvic organs so that when one of these organs is inflamed, its associate organs are likely to be involved in the disease.

That chronic ovaritis is less amenable to treatment than the acute, is also to be expected, from the fact that all chronic diseases are more intractable than the acute form of the same disease. But, after all, suppose, after an exhaustive examination, torturing the patient (girl perhaps) half to death, may be, with pain and mortification, you have really succeeded in discovering that she has simple, uncomplicated inflammation of one or both ovaries, whether acute or chronic, of what material advantage will it be to you in a therapeutic point of view, over what you would have possessed, had you failed to differentiate, exactly which one, or how many of these organs were affected.

From an allopathic stand point, eminent authorities

state that many cases will baffle treatment, while all will prove little amenable to it; that they recover in time it is true, but these recoveries have little connection with the treatment.

We are supposed to do better however, and to be able to produce a more satisfactory record. This is certainly to be desired, and therefore our best energies should be bent in this direction and I trust we may finally, perhaps shortly reach far more satisfactory results than have thus far attended even *our* mode of treatment in inflammation of the ovaries.

OVARIAN DYSMENORRHOEA.

BY MRS. M. B. PEARMAN, M. D., St. Louis, Mo.

There has been much discussion as to the existance of such a disease as Ovarian dysmenorrhœa. In my opinion we often fail to relieve cases of dysmenorrhœa because we look for the cause in the cavity or neck of the uterus when it is probable that a great many cases are due to disease of the ovaries or oviducts. Abnormal conditions of the ovaries may certainly interfere with the normal development of the Graafian vesicle, also any disease of the tube, as salpingitis, etc., may, by arresting the passage of the ovum, interfere with the monthly flow, thus causing dysmenorrhœa. If more proof of the possibility of ovarian dysmenorrhœa were necessary, we have it in recent research by which it has been determined that the endometrium and ovaries are developed from the same subdivision of the blasto-dermic membrane only attaining entire separate individuality at a late stage of development.

My belief is that any abnormal condition from a slight inflammation followed by even the slightest induration, to those cases where extensive adhesions bind down the ovary preventing the possibility of normal development of the

vesicle, may have its reflex influence on the catamenia, causing great pain.

These conditions certainly influence the endometrium and anything influencing this membrane certainly may influence the monthly cycle. This degree of influence seems to be largely controlled by temperament; women of nervous sanguine temperament, being exceedingly sensitive to even a slight amount of irritation of the ovaries, while others more phlegmatic may have hypertrophied, or otherwise abnormal ovaries and experience little pain. I think because our gynæcologists often meet with cases of ovarian trouble where either the patient is too phlegmatic or the stage of active influence upon the menses is past, is one of the reasons that some practitioners do not recognize the influence of the ovaries in dysmenorrhœa.

In ovarian dysmenorrhœa we frequently find the pain located at some point removed from the seat of the flow, but undoubtedly as much caused by the attempt of nature to establish the physiological function as if the pain were located in the part. Like other forms of painful menstruation it is relieved when fully established, hence it would seem proper to consider ovarian dysmenorrhœa as suffering directly traceable to a diseased condition of the ovaries.

Many practitioners, in cases of dysmenorrhœa that do not readily yield to treatment, recommend the trial of the physiological changes that take place during pregnancy. Pregnancy cures some cases and relieves some, but my belief is that these cases result from flexion, version, or some form of lesion of the cervix, and in those cases where pregnancy does not cure we will find ovarian trouble the true cause.

Some writers give uterine disease, especially of the cervix as the reason for a larger proportion of non-parous women having dysmenorrhœa than parous. Why a diseased condition of the ovaries is not recognized as a factor is difficult to understand. In many sterile women suffering

with dysmenorrhœa, I find the first indication of the approaching catamenia to be pain in the region of the ovary; the pain seldom being relieved until the flow is ended, and in some continuing as many days after, as it was present before; thus giving undoubted evidence of the diseased condition of the ovary, with a possibility of the diseased condition being the cause of sterility.

Emmet says, he doubts one diseased ovary having any influence over the uterus, and that certainly the uterus has no influence over the ovaries.

This we cannot adopt without investigation. If one ovary may ovulate and furnish all the conditions of menstruation, why not one ovary when diseased be capable of exercising reflex action upon this function? Emmet also gives the influence of inflamed and congested ovaries in producing great pain in the sacrum. May not this be? Yes, is it not almost certain to be reflected upon the endometrium?

There is a tendency to divide ovarian dysmenorrhœa into numerous classes, specifying each tissue involved and the different changes, but for practical purposes to be able to say that the ovary is the exciting cause is sufficient. From the history of the case as to the cause of the ovarian trouble, and from the subjective symptoms (as few objective symptoms are attainable) we may be able to diagnose and prescribe.

Prognosis. We will not feel immediately alarmed about the cases of ovarian dysmenorrhœa coming under our care, but will not assure our patients of a speedy cure. We may not be certain of the exact condition existing, hence may not be able to prescribe with precision. But even with a satisfactory diagnosis you may fail of the result you should obtain if you could control the patient and keep her from excess, mental, physical or sexual.

We frequently find a change of climate and surroundings, and absence from home cares necessary to a favorable prognosis.

Finally, I assure you that while we may be enabled to successfully argue the existence of ovarian dysmenorrhœa, and to conclusively demonstrate its importance, it is no easy task to diagnose, and if this paper acts as a reminder or stimulus for arguments which shall teach us to certainly, early, practically diagnose our cases, it will have accomplished its mission.

OVARIAN NEURALGIA.

H. K. BENNETT, M. D., Fitchburg, Mass.

Synonyms: Ovaralgia, Oophoralgia, Irritable ovary, Pain in the Ovary. Definition: Neuralgia, nerve pain, is a term which is frequently employed both technically and popularly, in a somewhat loose manner, to designate pain, the origin of which is not clearly traceable. In its strict sense it denotes the existence of pain in some portion, or throughout the whole distribution of a nerve without any distinctly recognizable structural change in the nerve or nerve centers. This strict definition, if adhered to, however, would not be applicable to a large number of what are considered to be cases of ovarian neuralgia. For it is well known that in not a few instances the pain is connected with some source of irritation by pressure, or otherwise, in the course of the affected nerve. It may be stated generally that ovarian neuralgia rarely occurs in the midst of good health. On the contrary its existence usually betokens a depressed or enfeebled state. From this standpoint it will be observed that ovarian neuralgia as a disease *per se*, is extremely rare.

Ætiology. Constitutional diseases either inherited or acquired are among the most powerful of predisposing causes. In conditions of the system from improper or insufficient food, or as the result of any drain upon the body, or in anæmia from any cause, or in disease poison, ovarian neuralgia is a frequent concomitant.

Again, any strain upon the nervous system, is one of the predisposing causes. Among exciting causes of an attack of ovarian neuralgia by far the most common is exposure to damp and cold. Irritation of the nerves of the ovaries may be produced by numerous other causes, such as inflammation of the stroma of the ovary. It is also of reflex origin. The structure of the ovary and its nervous connections fully explain why abrasions of the external os uteri, laceration of the cervix, and cicatricial tissue involving the lower segment of the cervix are recognized causes of ovarian neuralgia.

Diagnosis. In forming a diagnosis of ovarian neuralgia we must depend almost wholly upon objective symptoms. The pain of ovarian neuralgia is almost always remittent in character, with absence of fever and acceleration of pulse which always attends an attack of peritonitis, and in which the pain is continuous and aggravated by pressure.

In ovarian neuralgia the pain is increased upon light pressure (by the rectal or vaginal touch) and oftentimes removed entirely by firm pressure. The pain is usually localized, and generally only one side is affected. It is not unfrequently periodic, occurring at a certain time of day or night. It varies in intensity, being often of the most agonizing character, while at other times it will be less severe, presenting more of a tingling sensation. From sacralgia, ovarian neuralgia may be readily distinguished by making firm pressure upon the lower part of the sacrum, which will increase the pain if it be of sacral origin, but the reverse if it be ovarian. Ovarian neuralgia dependant upon reflex causes, when arising from a diseased or injured cervix, will be produced or aggravated by pressure made upon the cervix during a digital examination. Ovaritis is readily diagnosed by its constant pain, great sensitiveness upon pressure, enlargement and usually more or less displacement. During an acute attack of ovaritis, fever and acceleration of the pulse are generally present.

OVARIAN DISPLACEMENTS.

H. P. HEDGES, M. D., Chicago, Ill.

It is well at the outset of this investigation to recall and bear in mind the size, shape and position of the normal ovary, its relation to the uterus and contiguous parts, its peculiar recurring functional activities and its susceptibility to disturbances affecting other pelvic organs.

From the lateral location of the ovaries in the pelvis between the broad ligament, it must be observed that dislocations are possible. The causes of the deviations will be considered separately with each of the different forms of displacement. We divide ovarian displacements into two classes, intra-pelvic and extra-pelvic.

The latter form is called ovarian inguinal hernia. This variety of displacement is nearly always congenital. As they cannot be manipulated back into the pelvis, the best and only cure is extirpation. The local pain and the tenderness in these cases, especially at the time of menstruation are main conditions calling for attention.

We come now to consider the second and much larger class of ovarian displacements, the intra-pelvic. The most infrequent form of intra-pelvic dislocation is the anterior. In this deviation the causes are rarely clearly defined. A direct shock from falling downward and forward, or jumping from a height, have caused it in some cases. In all cases of anterior intra-pelvic displacement there is the most distressing train of reflex disorders. The terrible periodic menstrual agonies seem to cause neurotic affections of the most intractable character.

So little can be done to relieve in this case that a surgical interference is a resort the patient willingly accedes to, hence painful and protracted cases are cured by the removal of the ovary.

We now come to the most frequent of ovarian disloca-

tions, the posterior or retro-uterine. The ovary, by reason of its position on the posterior surface of its respective broad ligament, which slants downward and backward, has a tendency to glide into Douglas' pouch. Sometimes we say that the ovary is in a state of lateral displacement. This is a stage of the dislocation where the ovary is in the more shallow fold of the posterior uterine cul-de-sac. But when it falls still lower, it becomes a complete prolapsus. The normal ovary thus displaced may give no symptom and hence some of the old authors gave no thought to the displacement.

Causes:—First, increase in weight from inflammation, acute or chronic, or functional. Second; from falls, jars, or any shock given on the feet or by sitting down suddenly. Third; displacements of the uterus. Fourth; coughing, severe vomiting, or straining at stool. Fifth; relaxed and weakened attachments. Sixth; and last, crowding downwards of the ovary by tumors and growths from above. Peri-uterine cellulitis.

The symptoms where the normal ovary is in a state of retro-uterine prolapse, if any, are, a dragging pain in the groins and down the thighs, a feeling of pressure or constriction of the rectum, a sense of weight or bearing down in the pelvis, a numb sickening pain on defecation with faint nausea. In cases where the ovary is inflamed or enlarged the pain is increased. Such an ovary causes an aggravation of all the symptoms given. Besides these there is a dull throbbing pain, burning in the rectum and uterus, shooting pains in the hips and sacrum. The menstrual return always brings an increase of the pain, and during these severe attacks the ovary is in danger of becoming bound down by adhesions.

Local examinations are necessary to verify diagnosis. The first point to observe on digital examination is the extreme sensitiveness to even the most gentle movement of the os uteri. The examination nearly always causes pain

beyond any apparent reason. This is significant. On passing the finger, or better the two first fingers, up into the cul-de-sac the ovary can be felt as an oval shaped, flattened, moveable body, lying to one side or behind the cervix. It may be differentiated from hard, rounded, fecal matter by the unendurable pain on pressure.

Thus it is that the diagnosis is rarely difficult. The reflex symptoms are often distressing. Extreme irritability and various nervous derangements may extend into hysteria, melancholia and even pronounced insanity. Displaced ovaries held down by adhesions are the most incurable.

In the treatment the first thing is to replace the ovary. Place the patient in the knee-chest position,—lift the perinæum and thus the vagina will fill with air. The uterus if retroverted or flexed will drop back into place. Often the ovary will glide into place also. If this is not successful use the broad end of a uterine repositor or a sponge holder with a sponge large enough to distend the vault of the vagina. The most discouraging condition is the tendency to recurrence, necessitating the use of some support, such as an elastic ring pessary or the bulb pessary. In replacing the inflamed and enlarged ovary use the same means as in the displacement of the normal ovary; but it will sooner return and it is necessary to tampon the vagina medicated as to symptoms. In some cases packing the vagina with oakum finely picked is excellent. By the careful use of a tampon and a pessary, pushing up the uterus so as to elongate the vagina and thus pulling steadily on the ovarian attachments we are enabled to loosen even an adherent ovary. Those cases of ovarian prolapse which are incurable, and in which the agony is too great to be borne, require extirpation.

In conclusion it will be noticed that I have recommended no homœopathic remedy for displacements of the ovaries. There is none for dislocation proper. As

well prescribe pills to set a dislocated humerus. Nevertheless I wish it understood that I believe that no homœopathic physician can direct and manage to a successful termination any such case as is given in this paper, so well as to use, conjointly with his surgical and gynecological measures, the constant and carefully selected homœopathic similar to the symptomatic indications as they arise.

A FRESH SIR ORACLE.

HOTEL VENDOME,
BOSTON, MASS., May 22, 1885. }

Editor Journal of Gynecology and Obstetrics:

Owing to a press of professional and other work, I did not read the April number of your interesting journal till to-day, which will explain my silence upon the rather absurd, though amusing effusion, from the hypercritical pen of Dr. Gage, in regard to an article of mine in the previous number of the Journal, entitled "Clinical Cases."

I had no idea that the few cases of my practice, so plainly described by an unpretending professional man like myself, would have disturbed the learned Doctor, or stimulated him into a fit of sapient criticism, in which his self-sufficient airs are funnily displayed. I must thank him for his patronage and clever opinions, I suppose, however off-hand and dogmatic the manner exhibited; but must politely decline to accept them till recommended by sufficient experience and better authority.

We are first informed that in Case I, reported by me, I "should have extracted the placenta before leaving the patient and before the os was allowed to contract." I think that, had the Doctor carefully read my remarks, he would not have so heedlessly vented this criticism. I was particular in reporting the means employed to extract the placenta, and also my failure; that I was about to adopt more decisive measures when the source of danger (hæmorrhage) suddenly ceased, and that in consequence of the exhausted condition of my patient, I considered it better

to delay interference until amendment appeared. Soon afterwards, no alarming symptoms having manifested themselves, my patient was suddenly called out of town. When, on her return, I urged surgical intervention, she positively refused, preferring to trust to nature for her relief, unless her condition became worse.

My sage critic would have emptied the uterus *coacte qui coacte*, before leaving the patient. But you, Dr. Porter, who have had more experience—to extend the contrast no further—quietly disposed of this dictum by the parenthetical editorial remark: “Good advice, when it can be carried out.” This is not unlike our school-boy’s reply when a doubtful feat is promised, “It’s easier said than done,” in certain cases.

I may add that, though not in favor of trusting to medicines in cases of retained placenta after abortion, there are excellent authorities for their employment as well as for complete abstinence from surgical procedures. Our own Dr. H. N. Guernsey, says: “As to forcible removal, I have given that up entirely in abortions at second, third, or fourth month, and now trust entirely to medicines.” In Denman’s “Obstetric Aphorisms,” page 120, we read: “It is not now thought necessary or proper in abortions to use any means for bringing away the ovum, or any portion of it which may be retained, with instruments or manual assistance.” McClintock, in his edition of Smellie’s midwifery, puts the case as follows: “He (Smellie) steers very judiciously between the two extremes of hasty, overzealous interference on the one hand, and a purely negative, temporary course on the other. * * * * * Although, as a general rule, prone to operating, yet his (Smellie’s) large experience and correct observation had taught him that time and patience were often the best auxiliaries in those particular cases, and he points out very plainly when we may interpose our manipulations with a prospect of doing good.”

I shall retain in "memory's waste," though some may think I should consign it to the waste basket, my critic's ingenious method of manufacturing a temporary placental forceps—though probably not original, it may have its uses.

We are told, as if by one who had authority, "There is no such thing as a four month's placenta being absorbed, it came away *sometime*." The Doctor may be right, for I have in this case only the word of my patient, who, however, is an intelligent woman; but his opinion will not over-ride the following authorities: Ramsbotham says, in his *System of Obstetrics*, page 397, "Cases are on record in which the placenta never passed from the uterus at all; it having been supposed that the whole, or the greater part of it, had been absorbed by the action of the uterine vessels; and some physiologists are strong advocates for ascribing to the uterus the power of absorbing portions of placenta when left after the child's birth." Then Naegele gives four instances of permanent retention of the whole placenta (*Medical Gazette*, Volume III, page 189). Professor Salomon, of Leyden, mentions "two instances in which no portion of the placenta at full time can pass away," (*Medical Gazette*, Volume XIV, page 334). Velpeau cites three similar cases, (*Traite des Accouchements*. Article, Resorption du Délivro). Ingleby on Uterine Hæmorrhage, page 206, expresses his belief in the possibility of absorption. Dr. Rumsey, in an inaugural thesis which appeared in 1837, says that when the placenta is not expelled it "may become organized and amalgamated with the structure of the womb itself."

To show, perhaps, that he is no mere apprentice or amateur, Dr. Gage informs us that he has had clinical opportunities—that he knew of a case "where the placenta was retained three months." I hope he followed his opinion, above expressed—that he did not fail "to extract the placenta before leaving his patient." I may fail, however, to extract a confession in this case.

The Doctor feels anxious, also, to inform me that my Case II, was simply a "false alarm." This is another instance of his desire to "carry coals to Newcastle," as I did not assert it was not a false alarm. My reason for mentioning the case is fully given in the words: "My impression is that, were physicians oftener called in at an earlier stage they would find the apparent symptoms of the process of labor some weeks sooner than is generally supposed with most practitioners." Dr. Gage tells us he "cannot comprehend" this sentence. He said "paragraph," but he must mean sentence, as the whole account of the case is contained in one paragraph. I am sorry I cannot endow him with clearer perceptive faculties, but those of a very modest sort should readily catch the meaning of so plain a sentence.

My critic, however, can see, if not the sense of a simple sentence, an analogy a long way off, or in familiar language, a small hole in a stone wall. His case has no resemblance to mine. The merest novice in medicine knows that the "period of gestation is longer in some than in others," and "that women often reach their time of confinement without being sure of the date." But what has that to do with the fact, to which I called attention, that the processes of labor often begin much earlier than most text-books lead us to believe. Owing to this not being generally known, young practitioners have not seldom, in finding the os somewhat dilated, kept manipulating the womb till labor was started, which labor proved tedious and trying to the patient.

The Doctor's sentences themselves are not always of the clearest. For instance, in writing the case which he cites, without any "rhyme or reason," he says: "I looked upon it as a threatened miscarriage (?) and after making an examination, found the cervix completely obliterated and the os dilating," and yet he "assured her she had reached full time, and in a few hours," etc. I can discern his

meaning, but I cite the language to show he has evidently mistaken his abilities, in attempting a role rather beyond their range. When he speaks of "miscarriage," of course he means "premature labor."

With reference to the Doctor's parting shot that, it appears to him "puzzling" I should report other than obstetrical cases in an obstetrical journal. I may explain that the "clinical cases" were sent to the *Medical Advance* for publication, and appeared in the *Gynecological Journal* without my knowledge. The make-up or form of the combined journal might have suggested a "transposal," as the printers say, or error in the location of the paper.

I may thus console the learned Doctor by admitting some cause for his honest confession that "this case is really a puzzle"—particularly when he can get puzzled, as we see, without cause.

A word of advice, in conclusion, to critics of the mental calibre of Dr. Gage: Always read over carefully, an article, ere you attempt to find fault with it, and before playing Sir Oracle, be sure you have something worth saying. Be equally certain that you have caught a confrere "nodding," lest you find you have but "caught a Tartar," who, for your own good and the sake of truth, will be compelled to expose your ignorance and presumption.

PROSPER BENDER, M. D.

[The Editor again calls attention to "note to contributors and subscribers" on first page.

We have permitted Dr. Bender to reply to Dr. Gage for two reasons. First, because he had been criticised in an article published in this journal; and, second, because Dr. Bender's reply is not only instructive but interesting, and, aside from his scalpel language, it makes a good article. Now we will strike a balance and close the books on this subject.—P]

AMERICAN INSTITUTE.

BUREAU OF GYNÆCOLOGY, 1886.

L. A. Phillips, M. D., Chairman.

S. P. Hedges, M. D., Secretary.

Subject—Diagnosis and Treatment of Organic Diseases of the Uterus.

MEMBERS.

L. A. Phillips, M. D., Boston.

S. P. Hedges, M. D., Chicago.

Phil. Porter, M. D., Detroit.

H. K. Bennett, M. D., Fitchburg.

M. T. Runnells, M. D., Kansas City.

L. L. Danforth, M. D., New York.

B. F. Betts, M. D., Philadelphia.

C. B. Kinyon, M. D., Rock Island.

Robert Hall, M. D., Providence.

Mrs. C. T. Canfield, M. D., Chicago.

Five theses are to be written and presented, each to be discussed by one of the remaining five members of the Bureau. Subjects already assigned

HOMŒOPATHIC GYNÆCOLOGY.

For common sense, sound homœopathic doctrines, and the speedy cure of our patients suffering from either acute or chronic ovarian disease, we commend the foregoing remarks of Dr. A. I. Sawyer, to the careful and thoughtful consideration of the profession, whether general practitioner or gynecological specialist. A "doubtful prognosis" would not so often be given and a much larger percentage of our patients would be cured if we followed this therapeutic hint. "A more satisfactory record" need scarcely be expected until we adopt the only means by which it can be secured, *the individual homœopathic treatment of our patients*:

"That chronic ovaritis is less amenable to treatment than the acute, is also to be expected, from the fact that all

chronic diseases are more intractable than the acute form of the same disease. But, after all, suppose, after an exhaustive examination, torturing the patient (girl perhaps) half to death, may be, with pain and mortification, you have really succeeded in discovering that she has simple, uncomplicated inflammation of one or both ovaries, whether acute or chronic, of what material advantage will it be to you in a therapeutic point of view, over what you would have possessed, had you failed to differentiate, exactly which one, or how many of these organs were affected."

SHORT-STOPs.

Dangers in placenta previa: Death of the mother from hæmorrhage, and of the child from asphyxia. The maternal mortality is one in four; foetal mortality, one in two to three.

Placenta previa: As soon as the ovum enters the womb it should be, and usually is, arrested by a fold of mucous membrane. If these mucous folds are not prominent enough, it may advance until it arrives at the os internum, where the placenta will be formed. It is therefore found principally in the multiparæ, and in those whose organs are in a relaxed condition.

Management at full term: 1. Introduce one or two fingers within the os, and dissect the placenta from the uterine wall for about three inches from the os uteri in all directions, pushing it to one side, if necessary. 2. Rupture the membranes, and if there is an unfavorable presentation, turn the child, and make the breech engage in the os; or, if the head presents, the forceps may be used, if speedy delivery is necessary. This partial detachment of the placenta will almost inevitably arrest hæmorrhage. The strength of the woman is then the main point to be cared for, and if in a reasonable time the uterus seems incompetent, the child may be delivered by art.

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NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal, should be exclusively for its pages; no others desired.
 2. Illustrations required for original contributions, will be furnished at the expense of the journal.
 3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
 4. Personal controversies, not being of interest to the profession in general, can not be published. Explanations may be made through the editor. This rule will be strictly adhered to.
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SEMI-ANNUAL MEETING MASS. SURGICAL AND GYNÆ- COLOGICAL SOCIETY.

The semi-annual meeting of the Massachusetts Surgical and Gynæcological Society was held in Boston, June 24th, 1885.

Ella G. Smith, M. D., of S. Boston; Chas. Lloyd, M. D., of Lynn; Thos. C. Conant, M. D., of Gloucester; and Frank A. Gardner, M. D., of Salem, were elected to membership, and the resignation of Allan M. Ring, M. D., was received and accepted. A very interesting and valuable communication from E. M. Hale, M. D., of Chicago, was read by Dr. Southwick, for which a vote of thanks was extended to Dr. Hale, and the Publication Committee was requested to have it published as early as possible for the benefit of all who might wish to study and profit by it.

A practical and instructive paper upon "The Electro-Therapeutics of Menstrual Anomalies" was read by W. H.

White, M. D., of Boston. A report of "A Peculiar Case, with Autopsy," by J. F. Hadley, M. D., of Waltham, and notes of clinical cases by A. M. Cushing, M. D., of Springfield and G. F. Forbes, M. D., of W. Brookfield.

Because of dissatisfaction with the manner of publication by the *Hom. Obst. Journal*, the transactions of the society were referred to a publication committee, consisting of L. A. Phillips, G. R. Southwick and Chas. R. Brown, to be published at their discretion through such mediums as they may select.

Dr. Southwick, as chairman of the section, very properly complained of the lack of courtesy as well as interest on the part of many of the members whom he had requested to contribute, some not even replying to his letter. As a matter of fact, in nearly all societies a few workers have to do what is done, the majority contributing at most only their presence, and generally not even that. With a view to bringing out the members in force, and disposing of some of the surplus funds in the treasury it was voted to make the annual meeting in December a double session, afternoon and evening, with a collation between. A full attendance and an interesting program is anticipated.

ON CARDIO-UTERINE REMEDIES.

BY E. M. HALE, M. D., Chicago.

There is a condition of the human body known as *atonic*. This condition is defined as an enfeebled state of all the organs and tissues. Not always are all the organs and tissues enfeebled to the same degree. In some patients it may be the liver which is most *atonic*; in others, it is the kidneys. In woman, it is oftener the uterus. But back of this local organ-atony, we often find that an enfeebled *heart* is the prime cause of the local mischief.

It may be that some particular organ becomes atonic previously to the general systemic feebleness, and this local disorder will lead to such a general atony that the

heart suffers secondarily. In turn, this cardiac atony increases the local atony.

For example—the patient may have had uterine catarrh—this has led to uterine irritation, with mucous endometritis. This leads to exhaustive discharges, frequent menstruation, miscarriages, etc. Soon the general strength suffers; the blood becomes impoverished; digestion is interfered with; the nutrition of the body is arrested; then the heart becomes enfeebled, and, in consequence, the circulation in the uterus becomes sluggish, and aggravates the local disorder to such a degree that we cannot remove it until we apply remedies that restore the vitality to the heart itself.

Another example: The patient, previously in good health with all her organs in good condition, may contract malaria, or become exhausted by over-work, or accidental hæmorrhage, or may contract some disease—like rheumatism—which may injure the integrity of the heart. The weakened heart fails to send a normal supply of blood to the uterus, that organ becomes anæmic, or its circulation becomes sluggish. In this condition it fails to perform its normal functions, and we find it enlarged, flaccid, and displaced.

In this state, all remedies directed to the uterus alone, fail to remove the local symptoms or the pathological state. The central organ of circulation must be reached and restored before we can expect to see any improvement in the local uterine disorder. We can, perhaps, best understand this subject by referring to analagous conditions in other organs.

When we have an enfeebled heart from functional, organic, or zymotic causes, we soon find that the kidneys, liver, or brain, suffer from lack of blood supply. The nutrition of these organs fails, and they readily take on degenerating changes, or loss of function.

In the liver we have passive stasis, leading to jaundice,

hypertrophy, and functional torpor. In the kidneys we have failure of secretion and excretion, leading to dropsy. Or we may find albuminuria, and possibly some of the conditions resulting in Bright's Disease.

In the brain, anæmia, loss of memory, insanity, or other disorders of the intellectual processes.

In these abnormal states of the organs above mentioned, all attempts to restore them to a normal condition by prescribing for the *symptoms*, will prove worse than futile. But when we direct our measures to the restoration of the powers of the enfeebled heart, we shall soon find that the organs which suffer will soon regain their normal functional activity. We must not forget that in such cases, medicines are not alone sufficient. We must resort to efficient, dietetic, and hygienic measures. We must see that the climatic conditions are favorable, that the mental condition of the patient is also favorable. Then the supposed remedy must be selected, and its use persisted in until we are sure that it is the remedy for the case.

This paper will deal with a class of medicines which I have designated as *Cardio-uterine*. I mean by this designation, certain medicines which have a specific affinity for both organs—the *heart* and the *uterus*. I propose to exclude such merely cardiac remedies as Caffeine (if indeed there are any). Perhaps all supposed purely cardiac remedies do affect other organs simultaneously.

The principal cardio-uterine medicines, so far as I am able to designate them, are: *Ergot* (*Secale*), *Cactus*, *Convallaria*, *Lilium tig.*, *Hydrastis*, *Ustilago*, *Digitalis*, *Cimicifuga*, *Belladonna*, *Sepia*, *Ferrum*, *Ignatia*, *Nux vomica* (*Strychnia*), *Arsenic*, *Aurum*, *Glonoine*, and *Amyl nitrite*.

I shall give the characteristic indications for these remedies, premising that I give them as the result of my personal experience.

Secale—The patient is thin and “scrawny,” or lymphatic.

tic, flabby and pale. The heart's action is feeble, quick; pulse contracted, quick, weak; veins full, dark; uterus heavy, apparently cedematous, deficient involution, passive hæmorrhage, blood pale, *slimy*, or dark-brown and foetid. Menses very scanty, or too frequent and profuse. (Dose: 2x trit. of fresh pulv. Ergot, or Ergotin 3x trit. The *Ergotin* is probably the best preparation. I like the effects of the "Syrup of Ergotin" in doses of ten to fifteen drops three times a day).

Ustilago—Is very similar to *Secale* and in some cases will give better results.

Cactus—The heart-symptoms are so well known that I need not repeat them. In consequence of the feeble and irregular action of the heart, the uterus and ovaries are subject to venous congestions. Hence we find in *Cactus* patients, dysmenorrhœa, violent crampy pains similar to the "constriction" pains in the heart. Hæmorrhages when the heart is acting badly. No organic lesions. The two species of *Cereus* have a similar action on the heart, and probably on the sexual organs.

Convallaria—The heart's action is very feeble, but with palpitation on the slightest exertion. It beats irregularly, its rythm is lost, and it is very intermittent. There is great dyspnœa, cannot lie down or walk. The uterine symptoms resemble those of *Lilium* and *Sepia*—sensations of aching, weight, bearing down, and even labor-like pains, with reflex symptoms of nausea, eructations, etc.

Lilium tig.—Heart very irritable, palpitation from every emotion, and from pain, especially when in the uterus and ovaries; fullness and coldness in the heart; sensation as if it were alternately grasped and released by a hand. These symptoms are relieved by lying on the *left* side. (The contrary in *Cactus*, *Digitalis*, and *Convallaria*.) The uterine and ovarian symptoms all point to neuralgic irritation, venous congestion, erethism and displacements. *Lilium* has all the symptoms of *Salpingitis*, until lately but little

understood. The one symptom of "burning spot in the region of the ovaries," is the key symptom. In no remedy is the reflex sympathy between the heart and the sexual organs so fully shown.

Hydrastis.—This remedy heretofore considered as a simple "tonic," has lately been shown to possess specific relations to the vaso-motor system. It causes primarily, contraction of the muscular coats of the arterioles—followed by relaxation and atony. It primarily causes strong action of the heart with increased blood-pressure, followed by muscular atony of the heart, with general feebleness of the circulation. In uterine diseases it is indicated in fibroid tumors, irregular and profuse menses, profuse leucorrhœa, with active congestion. (In these conditions it has been found curative by Dr. Schotz in appreciable doses 10 to 20 drops of the tincture.) I have also used it successfully, in chronic passive metrorrhagia—due to atony, fungoid growths, chronic leucorrhœa; or scanty, pale menses, with general loss of nutrition and assimilation.

Digitalis.—The action of *Digitalis* on the heart and circulation is so familiar to all that were it not to elucidate its dual action as a cardio-uterine drug, I should not discuss it. I do not think its usefulness in this sphere has been sufficiently appreciated.

The primary action of *Digitalis* in medicinal (not toxic) doses is to increase the force, and amplify the beats of the heart. In doing this, it floods all the organs with an unusual supply of arterial blood, increasing by this action the functional activity of every organ. The sexual organs are no exception to this rule. In the full recorded provings we find that it causes heat and turgescence of the male organs, with increase of power and desire, and even intense vascular and nervous irritation. Doubtless, the female organs are similarly affected.

I am aware that toxic doses produce directly opposite effects, but this is accounted for by the well known rule

that massive doses cause immediately secondary effects—without being preceded by the true primary.

The secondary effect of *Digitalis* is a failing heart, with feeble, irregular, intermitting pulse-beat. It fails to supply organs with their proper amount of arterial blood. All the tissues of the body become anæmic—their vitality and nutrition and functional activity languish.

A condition of venous stasis obtains, and in the sexual organs we find impotence, sterility and coldness. Active arterial hæmorrhage is a primary effect. Passive venous hæmorrhage is a secondary effect. So is scanty pale menses, ovarian torpor, and a whole train of parietic symptoms.

It will be perceived that the primary and secondary symptoms of *Digitalis* are very similar to those of *Ferrum*. The only lacking symptom is the blood impoverishment, the scarcity of red blood globules of the latter.

In high dilutions, *Digitalis* and *Ferrum* are homœopathic to active arterial hæmorrhage in florid patients. But it is rare that we find typical cases indicating their use.

I consider *Digitalis* almost indispensable in chronic cases of disorder of the uterus and ovaries, especially those which occur in women who have borne many children, have had exhausting hæmorrhages or leucorrhœal discharges. In such subjects the general nutrition is below par. The circulation is feeble, and the uterus is nearly always in a condition of venous stasis.

When ulceration, chronic endometritis, or displacements occur in such subjects, topical treatment unaided by general restorative means fails to effect a cure.

We may prescribe *Arsenic* or *Sepia*, the two best remedies indicated for the local disorder, but we shall fail to cure, because they do not restore to its normal force the systemic circulation. But if we add to the topical treatment, and to *Arsenic* or *Sepia*, the judicious use of *Digitalis* or *Ferrum*, with appropriate diet and hygiene, we shall

soon find our patients improve in a wonderful manner. A word as to the proper dose of the latter medicines.

My personal experience has shown me that in anæmic and paretic cases, *Digitalis* should be alternated or combined with *Ferrum*. I have no fear of violating any scientific law, or of antidotal powers. My experience is above all theories, for the success of such a combination disprove them. My favorite preparation is a mixed trituration of *Digitalis folia*, 1x with *Ferrum phos.* 1x. One or two grains of this powder may be given one hour after each meal. This should be persistently continued for several weeks, and the improved condition of the patient will be very gratifying.

Cimicifuga.—This medicine acts upon the muscular and nervous structures of the heart. It quiets irritability and irregular action, of those tissues. If the patient is rheumatic, choreic, or of a melancholy temperament, it is specially indicated. It is not homœopathic to any structural lesions in the heart or uterus, but is a specific for a large number of functional disorders of those organs. Its action on the uterus is similar to its action on the heart. It relieves many of the symptoms of a rheumatic or irritable uterus better than any other remedy. *Caulophyllum* and *Viburnum* are its nearest congeners. It is homœopathic to those congestions of the brain and uterus which alternate with each other at or near the menstrual periods. It is of great value in the dysmenorrhœa and painful labors of neurotic or rheumatic subjects. The "pain in the left side," for which *Cimicifuga* is so useful is nearly always a reflex from uterine trouble. This pain often attacks the heart itself, and will then simulate *angina pectoris*; or, suddenly fly to the head causing that intense pressure and pain in the vertex, forehead and eyes so characteristic of the drug.

Belladonna.—The importance of this medicine in its cardio-uterine relations cannot be over-estimated. Its action

is peculiar. It shows its action in the heart, which it excites and irritates to an extent not known of any other drug. There is an "arterial storm," all the arterioles of the body are dilated, allowing the excited heart to flood them with a torrent of hot blood. The result is active congestion in all the organs of the body. The brain and uterus probably are the most affected. Not only does congestion obtain, but inflammation in its most acute form. It is both phlegmonous and erysipelatous. It extends to the ovaries, and all the glandular structures of the generative organs. The symptoms need not be given here, as they are familiar to all gynæcologists

Sepia.—This drug has not generally been considered a cardiac remedy. It has not been mentioned by any prominent writer except Dr. Ch. Müller, who gives as its characteristic symptoms—"trembling, convulsive action and intermittent pulsations." He admits that these symptoms are "not fixed diagnostic signs of any particular disease." He also says it is indicated when "on auscultation the actions of the heart are violent, unequal, intermitting, convulsive and trembling."

While I admit that there *may* not be any structural lesion caused by *Sepia*, the symptoms certainly point to some deep-seated functional derangement. We know that obstinate blood stasis in all the organs indicates *Sepia*, and that this stasis means that the heart is not doing its work well. I judge from the symptoms that while the *acting* forces of the heart may be excessive, the *radical* forces are weakened. The general aspect and appearance of the *Sepia* patient shows the presence of some blood dyscrasia, and that the heart is enfeebled in some profound manner. I imagine that the primary lesion is in the central nerve supply of the heart, and that it acts in sympathy with the generative organs. Certain it is that the numerous and important cardiac symptoms of *Sepia* should not be overlooked by the gynæcologist. I have found that it acts well in al-

ternation with Convallaria, or after Liliūm has been found unable to control the cardiac and uterine derangements.

Ignatia.—The heart symptoms of *Ignatia* indicate, primarily, increased tonicity and spasmodic action, up to the point of tetanic rigidity of the ventricles. This is followed by a period of exhaustion. It is a matter of surprise that so few cardiac symptoms are found in its pathogenesis. The active principle of *Ignatia* is Strychnia, and probably all its purely physical symptoms are due to this alkaloid. But the physical symptoms are probably due to some other constituent. What this constituent is, if any, has not been discovered. No drug affects the emotional sphere more than *Ignatia*. Even among the heart symptoms, the palpitations are caused by deep thought. Clinically it has been used for palpitation, and many functional heart disorders due to grief and other depressing emotions. *Ignatia* is to the emotional life of women what *Nux vomica* is to that of men. But, singularly, *Ignatia* may be the remedy for the emotional disorders of effeminate men.

Ignatia does not cause any structural diseases of the heart or the utero-ovarian system. All its cardio-uterine disorders are reflex or functional. Its symptoms in this sphere are those which must guide us in its selection. The true chief characteristic symptoms which guide me in the selection of *Ignatia*, are (1), the "deathly sinking at the pit of the stomach," (which is always an indication of nervous depression, and due to cardiac weakness,) and (2) the alternation of opposite mental and emotional states, partly hysterical, and partly due to irregular supply of blood to the brain.

Nux Vomica.—Of all cardiac remedies, next to *Digitalis*, *Nux* is probably the most important. We know how profound is its action on the spinal cord and the motor nerves. We know, that acting on the spinal nerve centers, it acts through them on both the striped and unstriped muscles.

The *primary* action of Nux, or its alkaloid Strychnia, is to irritate and finally tetonize all the muscles of the body. In the irritative stage, we find cramp-like contractions, tonic and clonic spasms, excruciating pains, and finally convulsive tightening of all muscular fibers.. The *secondary* action is paresis, torpor, and finally paralysis.

These dual effects are manifested on the heart and the uterus. Hence we get the anguish and pain in the cardiac region, the palpitation, the angina-like pains. Hence also we get the uterine spasms, labor-like pains, tenderness and sensitiveness, and other symptoms which simulate metritis. And here let me assert that, notwithstanding Nux is classed among the drugs which cause and cure metritis, I do not believe it is capable of causing inflammation in any organ or tissue. It simulates the *pains* and sensations of inflammation, but has not the heat, swelling or pathological conditions of inflammatory action.

Its sphere of action, on both the heart and uterus, is included in *spasm*, *pain* and *paresis*. No other medicine has such power to heighten reflex irritation by its *primary* action. No other remedy so deadens and abolishes reflex irritation by its *secondary* action.

Hence in all conditions and symptoms which resemble its primary action, it should be used only in highly attenuated doses. But when we have cases in which the symptoms simulate its secondary effects, the dose must be appreciable.

In the middle and high attenuations it will cure palpitation, cardiac spasms with dyspnœa, either idiopathic or due to reflex irritation. But in cardiac weakness, faintness, exhaustion and sinking, feeble pulse, cold extremities, we must resort to the lowest preparations. The same may be said of similar conditions of the uterus.

In paretic conditions of both the heart and the uterus, I prefer the preparations of Strychnia, generally the 2x or 3x triturations in doses of one or two grains three times daily.

Under the use of these doses I have seen the attenuated, thin and enlarged heart contract firmly and gain strength with each day of its use. I have also seen the enlarged, flabby, pale uterus gain in color and contract to its normal size. I have arrested passive hæmorrhages from the paretic uterus after protracted labors or at the change of life, by means of Strychnia 1x, after ergot had been vainly used.

I have seen arrested labor pains due to uterine failure, return strong and regular after Pulsatilla and Caulophyllum had failed. In chronic atony of the uterus, no medicine can compare with Strychnia. In such cases the heart nearly always sympathizes with the uterus. In fact, in many instances, the atonic uterus is but a consequence of an atonic heart. I believe that in many cases of chronic uterine disorder—in pale, lax, worn-out women—we would have far better success if we used this potent remedy more freely and boldly, alone or in alternation with other specific uterine remedies.

Aurum.—The preparations of gold are among the most potent cardio-uterine and ovarian remedies we possess. It is an analogue of Belladonna, Glonoine and Amyl nitrite. All act upon the vaso-moter centers in a similar manner. They differ only in degree.

The primary effect of Aurum is to relax the arterioles and capillaries. This allows the heart to throw the blood with greater force, and the result is a flushing and congestion of the skin and all the organs of the body. They do not, by this primary effect, impart greater strength to the heart, but take away a peripheral resistance which allows greater action. Under these primary effects the head (brain) is supplied with an unusual amount of blood, and a kind of joyous intoxication occurs. The liver is flushed and becomes swollen. The kidneys are flooded, and the tension in their arteries decreased, hence its active diuretic effects. The uterus and ovaries are stimulated by the ar-

terial blood, and profuse menstruation and even active hæmorrhage occurs. The ovaries are excited to greater activity, and ovulation is increased, together with a heightened sexual desire and power.

But there is another side to this picture. All over-stimulation is followed by depression, and the result is diminished physiological action, paresis, and blood stasis.

Hence, under the secondary action of gold, the brain functions become depressed, melancholy, and a tendency to suicide sets in, and finally dementia. The liver and kidneys become torpid, the secretion of bile and urine is lessened, and hepatic and renal induration occurs. The contracted kidney, and some form of Bright's disease are induced. The uterus becomes anæmic, and scanty menses, with induration and even ulceration obtains. The ovaries become torpid; ovulation may be nearly suspended, sterility occurs, sexual desire is extinguished, and impotence is established.

The proper use of gold in disease enables us to remove by its judicious administration many cardiac and utero-ovarian diseases. But unless the appropriate *dose* is selected we cannot use it successfully. If we prescribe it in conditions of the system resembling its primary effect, we cannot safely go below the 4th attenuation, and brilliant results have followed the use of the 10th and even 30th dilutions.

On the other hand, if we prescribe it for the anæmic brain, with feeble heart-action, or for ovarian torpor, sterility, impotence, scanty or absent menses, with feeble circulation, we shall succeed only with doses of the 1-1000, 1-500 or the 1-100 of a grain.

Glonoine.—The analogy between Glonoine and Belladonna is patent to all. The arterial storm of the former is more intense and more transient than the latter. That of gold is more lasting and persistent than either. It would be but a repetition to compare these remedies more fully.

Therapeutically we cannot expect to remove with Glonoine conditions which have become seated or chronic, while we can remove them with the preparations of gold. Glonoine causes an intense, active congestion of brain, kidneys, uterus and ovaries, but the primary effects are transient; so are the secondary. It is, however, a valuable palliative for those sudden arterial storms and sudden vaso-motor paralyses, which often attack neurotic subjects. Primarily it is indicated in very attenuated doses in congestion of the brain or lungs, accompanied with uterine congestion and hæmorrhage. Secondarily, and in lower attenuations, for sudden brain anæmia, uterine anæmia, and vaso-motor spasm in the peripheral surfaces of the body. The extremities are cold and shrunken; pulse almost imperceptible, and a feeble but *labored* action of the heart.

Amyl Nitrite.—This singular drug has a still more ephemeral action, like one of those tropical storms, bursting out of a clear sky, intense in violence, but soon over. It has been used successfully in attenuated doses in those sudden and severe *flushings* of young girls entering puberty, and in women at the change of life. In larger doses, in sudden attacks of heart-failure, syncope from shock, sudden suppression of the menses, or a failure of the uterus to start the menses, in neurotic subjects, when the surface and extremities are cold, clammy and blue. Its promptest action is by inhalation of a few drops.

DISCUSSION.

A. J. French.—I consider Dr. Hale's paper a very valuable contribution, but I think he should have laid more stress upon the *nerve centers* as the source of difficulty, as I believe that the heart symptoms only result indirectly because of the disturbance to the nerve centers. Muscles have no power in and of themselves—only through the nerves. *Atony* is due then to *nervous* weakness, and the remedies must be such as act specifically upon the nerve centers as nearly all of those mentioned by Dr. Hale do.

W. H. Lougee.—Dr. Hale's paper is a very interesting and valuable one, but I take exception to some parts of it. If he had spoken of the splanchnic nerve instead of the heart he would have been more correct. He speaks of Belladonna as dilating the arteries and causing *universal* congestion. How is this done, I would like to ask? Is the amount of blood increased by Belladonna so that increased blood pressure throughout the whole body results? I question some of the propositions.

L. A. Phillips.—I hope critical discussion of this paper will not be indulged in, as the author is not present to defend and explain, and as we are quite likely to have misunderstood some statements in hearing it read. When published it will be open to critical examination and dissection. I think this is a very valuable paper, but one which illustrates the necessity of having our transactions in print and available to each and all members, as we must *study* and compare such papers as this in order to derive any benefit from them. From simply hearing them read we cannot grasp and hold the many valuable indications and suggestions. One point, however, I wish to call your attention to, *i. e.*: the *mixing* of two remedies, as recommended in one instance. This I know would receive unqualified condemnation from very many, but I believe results may be thus obtained in some cases, which could not be, by the one or the other remedy alone, or by both in alternation, though I will allow that a proving of such a combination should be made.

Geo. R. Southwick.—I cannot understand how he can use Strychnia, as recommended, in the first and second dec. triturations without poisoning his patients. I believe he exceeds the maximum dose. As to the dilatation of the arteries by Belladonna, I suppose it causes a relaxation of the capillaries through the vaso-motor nerves.

H. K. Bennett.—The remarks of Drs. French and Lougee bring up a very important question as to the action

of drugs upon the *nerves* rather than upon *organs*. I am convinced that nearly all diseases are caused by some impression upon nerve centers or ganglia, and cure follows the administration of remedies which act in the same or a similar manner. By whatever means the impression is made, whether by medicine, by a shock, by imagination, or by faith, the desired result will follow. This is a matter which deserves our earnest thought and study.

David Foss.—I think the effect is first upon the blood and afterward upon the nerves. How does it reach the nerves except through the blood?

A. J. French.—The blood is simply a medium or carrier.

D. B. Whittier.—Dr. Hale's paper is very interesting to me as explaining some clinical surprises when unlooked-for results followed the use of certain medicines. To the list of remedies mentioned, I would add *Viburnum op.*, as valuable in cases having heart complications especially of a neuralgic character. It is allied to *Ignatia* and *Actea rac.*

F. A. Warner.—I am much pleased with Dr. Hale's paper and I would call attention to his first statement that the influence of womb diseases is to cause *atony*. Remedies act by sympathy upon the heart and also on the brain and spinal cord as well as upon the heart. Many times heart diseases are attended by pressure upon the *spine* and all the sympathetic disturbances must be considered.

L. A. PHILLIPS, Sec'y.

LOCAL TREATMENT FOR UTERINE DISEASES.

G. M. PEASE, M. D., Professor of Gynecology Hahnemann Medical College,
San Francisco.

Probably from the earliest moment when uterine diseases were recognized and received treatment from the hands of those who followed the calling of physicians, there has been great reliance placed upon local treatment. Experiments without number have been made, and each

aspirant for fame has lauded the result of his particular discovery; but alas, for the real welfare of suffering woman, the next follower was too often obliged to discard the methods so loudly praised by his predecessor, because they were not founded upon a law of cure, or because they had only served to mask the disease, and had never really cured. When Hahnemann brought to light the homœopathic law, he did that which took away very much of the necessity for local treatment, so that theoretically we never need to resort to local treatment for uterine diseases. The word "theoretically" is used because the practice of nearly every physician in the land is to make more or less use of local treatment, while perhaps striving by means of internal remedies to so effect the general system as to hasten the cure.

It should be the aim of the physician to treat every case according to the law of similars, but it does not follow that it is peremptorily necessary for the remedy to be administered by the mouth. We all know that effects are produced by the application of drugs to any or all parts of the body. If a sore or ulcer exists upon the outside of the body it is but common custom to make applications locally, or at least for the purpose of cleanliness, be they, perhaps, only soap and water, or something which is regarded in the light of a stimulant to the healing process. Therefore there seems to be no reason why a sore or ulcer upon the uterus may not be treated in the same manner. It is to be hoped that the limited advocacy here made of the value of local treatment may not be used as a reason for the disregard of a study of each case and strict symptom individualization.

The time should not be far distant when local treatment may be entirely dispensed with. At present we have many remedies which have been proven upon women, more or less extensively, and it is a matter of regret that many more have not received such proving. Still it is even now possi-

ble by analogy to select remedies which will cure the ills of women though never having been proved by her sex. Careful attention paid to the mental condition of a case will very often indicate the remedy which will cure symptoms not known to have been produced by provings, and it is here that the careful student will often find his way out of a seeming difficulty. In the practice of gynecology many cases are found in which the closest examination by questioning fails to find a perfect chain of symptoms; the ignorance of the patient or inability to properly describe her feelings being perhaps the reason, and the physician is left with only such symptoms as he can see.

Experience has taught that certain cases of erosions or ulcers—so-called—of the os are, to the eye, cured (or suppressed) by the use of nitrate of silver, hence the great temptation to use that agent. Or other drugs may have equal claims in other cases.

Experience has also taught that the suppression of disease externally manifested is hazardous, and he who wishes to use external treatment must calculate closely the dangers which lie beyond.

There is a recognized difference between an application for cleansing or emollient purposes, and one for so-called healing or suppression, and it is only the former that should receive full sanction.

The uterine troubles for which local treatment is most common are ulcerations, erosions, inflammations of the cervix and the body, and the catarrh which follows.

The impatience of the patient may lead the physician to depart from that course which in his inmost conscience he would consider the very best method of treatment, and consequently he will apply crude drugs to the diseased parts, hoping thereby to hasten, at least, the appearance of a cure.

The imperfect education of the masses is at least partially to blame for this, as they are apt to believe that "a

trouble hidden is a trouble removed," and until we can bring about a revolution in the public mind there will be more or less almost positive demand for some kind of local treatment. In the practice of the writer he owns up to the fact that there are a few drugs which are occasionally used locally, and must claim the mantle of charity for the ignorance which ever prompts such applications, but fortunately such practice is the exception and not the rule.

There are instances in which it is believed local measures are, however, really demanded, and there are those in which cellular infiltrations have become firm, and positive adhesions have taken place.

In such the application of *glycerine* upon cotton tampons carefully packed into the vagina will very materially soften the adhesions, while at the same time a remedy chosen as carefully as possible will tend to put the system in such a condition of general health that the softened infiltrations will be absorbed. As the constant and free use of *glycerine* may produce too much laxity of the vaginal walls, it is perhaps well to add a small amount of *alum* or *tannin* to the *glycerine*, before saturating the tampons, the astringent properties of which assist in keeping up the tone of the parts with which they may come in contact. In addition to this a valuable adjunct is the free use of the vaginal bath with water at an average temperature of 110° F.

Should there be considerable tenderness and inflammation this bath may be given several times a day, but not during the time when the *glycerine* tampons are in place. Cases of acute pelvic inflammation, and puerperal metritis and peritonitis are certainly much relieved by the use of the hot water. Strictly speaking these are local applications, but they are such as probably few of the strictest Homœopaths would condemn if applied to an inflamed external part of the body, as for instance a boil or carbuncle. More especially is this true of the use of hot water.

In the treatment of erosions and ulcerations (?) before referred to are instances in which the combination of glycerine with *hydratis*, *sanguinaria* or Kennedy's dark extract of *pinus canadensis* have brought about what appeared to be favorable results. *Iodine* has also been rarely employed for the same purpose that prompts the use of glycerine alone, or with the astringents. *Nitrate of silver* or any other strong caustic for the healing of ulcerations is to be strongly condemned, for not only does it not cure an ulcer, but rather produces an eschar which of itself is the center of irritation and may be the fruitful cause of subsequent malignant disease.

A simple ulceration, uncomplicated by cellutic adhesions, needs only the proper homœopathic, potentized remedy administered by the mouth and a cure will follow. It is believed that the disuse of local medicinal agents will be in exact ratio with the increase of knowledge of the *Materia Medica*.

OUR BERLIN LETTER.

(From our special correspondent.)

Fortune smiled again on your correspondent, and favored him on arrival at Berlin with bright, sun-shiny weather; a very desirable contrast to the cloudy, damp, and smoky atmosphere of London. Our professional brethren here are nearly twenty in number, and in view of the fact that here, as in France and England, they do not have the support of the government, they present a fair showing. In spite of opposition, they have built up a public charity in the shape of a polyclinic, the "Allgemeine Polyklinik des Berliner Vereines Homœopathischer Aerzt," established in 1878.

Clinics are held daily, except Sunday, by a staff of eight medical officers; consultation is free, but a small charge is made to cover the cost of medicine. The clinic

is very successful, one hundred patients treated daily being a minimum. No students are in attendance, nor does there seem to be any hope of obtaining the sanction of the government for homœopathic practice; yet the people ask for Homœopathy, and the success of the polyclinic attests its popularity.

On the other hand, there are fine opportunities for clinical experience and study in the allopathic institutions, in the neighborhood of Friedrich-strasse and Luisenstrasse, in the "Quartier Latin," of Berlin, containing the several institutions connected with the medical faculty of the University. Here is the "Anatomie," or dissecting room, and Royal Charite hospital with accommodation for 1,500 to 1,800 patients. In connection with the latter is the Pathological Institute where Professor Virchow instructs in morbid anatomy.

I will not bore you with the details of hospital management, but only say that Professor Lister's teachings as to antiseptic treatment are rigidly adhered to. So scrupulously exact are the operators, that, on the day of the operation, care is taken that no scurf shall fall from the head. Corrosive sublimate solution is much in favor, and a basin of this or of carbolic solution, is in frequent use during the operation. The room, the instruments, and all apparatus come in for a thorough washing in the antiseptic solution. The part to be operated on is scrubbed, and then shaven if necessary, and again washed. During the operation the guiding principle is that nothing shall touch the open wound that may have been in contact with an unclean surface.

Dressings vary with the fancy of the operator. Just at present "wood-wool," a new preparation, is much in favor and has found many advocates, as it is in itself an antiseptic material. Salicylic wool and iodoform gauze are used by a few as simple and easily applied dressings.

By the way, in speaking of the various "pathies" on

the continent, one must remember that the allopathic school, the so-called scientific system of medicine, is the only one recognized, as being in existence, except by the Homœopaths themselves. As Dr. Claude, of Paris, remarked to me, "The Homœopaths hold their license to practice from allopathic colleges, and if one speaks of a Homœopath, the question is asked, 'A Homœopath? What is that?'" For this reason the old school physicians meet homœopathic practitioners in consultation without asking or knowing what belief they may hold. In the face of such difficulties we see what efforts our brethren here must make to prevent an overthrow of what progress they have made, and besides this we can understand why (though here is where Homœopathy was first given to the world) so little advancement can be seen.

H. H. CRIPPEN, M. D.

Berlin, March 20, 1881.

A CASE OF PLACENTA PREVIA.

B. B. FREEMAN, M. D., Westville, Ind.

On November 5, 1884, I was called to see Mrs. H—, who lived five miles distant, the mother of four children, the youngest three years old. The messenger urged me to be in great haste, assuring me the lady needed assistance badly, that she had fainted from loss of blood, and he feared she was dying. I found her in her fifth labor, three weeks or more earlier than anticipated. She had had slight attacks of hæmorrhage at intervals of from one to three weeks for the past two months, but entirely free from pain,—had not thought the trouble serious, as perfect rest would control it. Three hours previous the present attack began, accompanied by slight pains, with rapid increase of hæmorrhage, which, upon examination, I found to be simply enormous. The patient was pale, surface cold, pulse small and fluctuating; she was conscious, could

swallow with great difficulty, could not speak above a whisper, and although she seemed to realize the immediate danger she was in, was surprisingly calm and collected.

On vaginal examination, I found the os so high up as to be scarcely within reach of the finger, dilated to nearly the size of a half dollar, within which the finger came in contact with a soft, spongy body, which I supposed was the placenta. The withdrawal of the finger was followed by a great gush of blood. I then introduced my hand within the vagina, and inserting the finger within the os found the placenta presenting, but that it was a *partial* presentation, the central portion, or body of the placenta being attached slightly to the left and posteriorly, while to the right of the os was the partially detached or free edge, from the broken vessels of which, and the denuded surface of the cervix, proceeded the hæmorrhage. Following this displacement I was with some difficulty able to reach beyond the free edge of the placenta, above which I recognized the presence of the membranes, and through which I could feel the foetal head. I then ruptured the membranes, a large quantity of water escaping, which I hoped would be followed by sufficiently firm contractions of the uterus to make such pressure upon the bleeding vessels as would arrest the hæmorrhage. A drachm of Ergot Tinct. was given hypodermically, and firm pressure made by the hands through the abdominal walls upon the uterus, externally. Ice was also applied to abdomen over uterus. In a short time these efforts were followed by increased contractions and lessened hæmorrhage. In fifteen minutes a second dose of Ergot was given. The labor now progressed favorably, a slight discharge of blood taking place at occurrence of each pain. A drachm of brandy was administered hypodermically; external warmth was applied by means of bottles of hot water, hot flannels, etc., which being persisted in, succeeded in rallying the patient somewhat from her prostration, and the ability to swallow returning with re-

newed strength, stimulants by the stomach soon placed her beyond present danger.

In three and a half hours from the time I first saw the patient the child was delivered, the placenta following in about twenty minutes. The child was apparently dead, but persistent efforts at resuscitation proved unexpectedly successful, and I left the parents a reasonably vigorous child.

In this very brief report of the treatment of this case, I anticipate the criticism of the advocates of version in Placenta Previa, either partial or complete. Without entering into a discussion of the merits of either mode of delivery, I may say that I cannot believe turning would have resulted more favorably in this case; nor do I believe the tampon would have more promptly nor effectually arrested the frightful hæmorrhage, nor produced a more favorable ending. The per cent. of death in these cases being reported at 1 in 3.6, I was well satisfied with the termination of the case, which, at its beginning, I certainly did not expect.

OÖPHORECTOMY.

S. S. LUNGREN, M. D., Toledo, Ohio.

After giving a brief historical sketch of the operation and the various names by which it is known, the conditions and objects for which it is performed are given as follows: Intractable dysmenorrhœa, hystero-epilepsy, convulsions, insanity dependent upon ovarian irritation, prolapsed ovaries, and ovaries in women having no uterus, and more especially for fibroids of the uterus attended by hæmorrhage which all other means have failed to arrest.

Results obtained have varied greatly with different operators, both as regards the benefits secured, and the rate of mortality following, the latter being quite as large as in the removal of ovarian cysts.

The results for arrest of hæmorrhage from fibroid tumors

are thought to be most satisfactory, yet *these* require careful examination, and that the operation is as yet only on trial. The author then describes the two methods of operating, viz: Abdominal, which is now almost exclusively employed; and second, the vaginal, with detailed directions for both.

OVARIAN DYSMENORRHOEA.

BY WM. E. LEONARD, M. D., Minneapolis, Minn.

The clinical history of a young lady of fifteen, who was under observation and treatment for ovarian dysmenorrhœa for three and one-half years, at the end of which time a growth was discovered, filling the entire right abdominal and pelvic cavity.

During these years she attended school, and was apparently well, but this growth increased rapidly, and exhausted the patient in three months. The post-mortem revealed a sarcoma of the right ovary, nine pounds in weight.

The points noted in the case are: First,—The inheritance of ovarian dysmenorrhœa. Second,—The palliative action of medicine, especially of *Lapis Alba*. Third,—The early and anomalous fatal result.

Query. Is there *noted* or *unnoted*, any experience by which the physician may take warning and anticipate such a result in ovarian dysmenorrhœa.

A MONSTROSITY.

Dr. E. R. Freeman, of Wapakoneta, Ohio, sends the following as illustrative of the influence of external impressions upon the foetus in utero: "On May 5th, of this year, I delivered a woman of a female child, with a head resembling that of a dog; the nose was flat and the ears pointed. The eyes projected above the cranium like

those of a dog. From the mouth down it was a well developed child, measuring six and a half inches from point to point of the shoulders. It whined like a puppy instead of crying. Its head was flat on top and in the center was an opening about the size of an old-fashioned copper cent, through which the convolutions of the brain protruded, without any covering of scalp or membrane. The child lived almost five days, finally dying of cerebro-spinal meningitis. The mother claimed that during the second month of pregnancy a little dog attacked her and she became greatly frightened."

ABSTRACTS.

SUB-INVOLUTION.

Comparatively little has been written on the subject of sub-involution of the uterus, much less than the importance of the subject demands. An exhaustive consideration of the subject would furnish abundant material for a volume, and although it is impossible to touch upon the subject in all its important bearings in a single article, yet a few words may be in place by way of directing the thought and attention of the reader to a more careful observation of the condition in actual practice.

Our attention has been repeatedly called to the fact that a very large proportion of all the cases of chronic uterine disorder date from parturition. Thomas, says, "compared with interference with involution, all other pathological influences become comparatively insignificant" as a cause of chronic uterine disease.

We understand that the stimulus of gestation develops the normal uterine parenchyma by growth of existing structures and by new formation during the entire pregnant term.

Immediately after parturition has occurred, a retrograde evolution begins, which rapidly restores the uterus to its original condition, occupying a period of from forty to fifty-five days, until the womb has returned to the normal state of the non-gravid organ.

Any cause which retards or prevents this retrograde evolution, produces the condition under consideration, which is called by different authors non-involution, or sub-involution, or arrested retrograde evolution.

The cause may be a mental shock, or non-lactation, especially in those cases where the child does not live, or in case of an abortion, or it may be that very prevalent habit of rising too soon, or the too early resumption of the sexual act, or perhaps the retention of a small blood clot, or shreds of membrane, or a small piece of the placenta within the uterine cavity.

The difficulty is one of great frequency, quite often occurring and quite often overlooked, and its importance cannot be overestimated, whether regarded as a pathological condition or as an etiological factor, in the long train of evils which will surely follow. There is a disagreement between writers as to whether the condition is the disease or the cause of disease. It is certain, however, that by assisting the normal involution of the uterus a long train of unpleasant symptoms can be averted. Continental writers, however, are now very generally agreed that there is no difference whatever between the continued sub-involution and the disease universally called chronic metritis. The symptoms and pathological conditions in both cases are absolutely the same.

The following symptoms will not all occur in every case, or they may not immediately occur, but are likely to develop with the continuation of the disease. The patient first complains that she does not feel as well as she thinks she ought after a comparatively normal confinement, she does not regain her strength, there is languor, frequent head-

aches, principally on the top of the head with soreness of the scalp, there is almost complete loss of appetite, general weakness and despondency. As the disease progresses, there is backache, pains throughout the pelvic region, soreness more or less severe over the fundus uteri, and perhaps over one or both ovaries, also a sensation of heaviness, or weight, a dragging in the lower abdominal region, with a tendency to support the abdomen with the hands; there will probably be an excessive sanguineous discharge with leucorrhœa, bowels constipated, more or less irritation of the bladder, with perhaps an almost constant desire to urinate.

The symptoms point unmistakably to the womb as the seat of the disorder, and an examination per vaginam will reveal a descent of the womb, with evident engorgement. But the fact which most attracts the attention of the physician is the size of the womb; it is nearly as large as immediately subsequent to confinement, and its enlargement resembles that of the pregnant condition in its uniformity. The treatment suggested must be begun immediately, as the condition soon becomes chronic, and its amenability to treatment is lessened. First, absolute rest in bed must be enjoined, mental quiet, a mild, light, easily digestible diet, perfect cleanliness, and the use of the vaginal douche once or twice daily, a regular and normal condition of the bowels. * * * * Electricity is a most potent adjuvant, and if used in the form of the mild *galvanic* current will rapidly produce an amelioration of the symptoms, and if used immediately subsequent to confinement will absolutely prevent the conditions and the long train of evils which will surely follow, and will restore the womb rapidly to its normal condition.

It is the writer's positive opinion that the galvanic current judiciously administered early, will accomplish in three weeks in assisting the normal involution of the womb, what nature requires six or eight weeks to accomplish, without a

single untoward symptom, and is thus especially applicable to those cases where circumstances seem to force them to resume their usual tedious daily round of duties earlier than is beneficial to a rapid and complete natural restoration of the uterine parenchyma.—*Chicago Medical Times*.

[There is no disease in gynæcology more amenable to proper homœopathic treatment than subinvolution. The results from therapeutical treatment are so gratifying to the average Homœopath that he often delights in securing from his brother Allopath, patients who are suffering from this affection. Hot water vaginal irrigation, *in large quantities*, with the *indicated remedy*, will relieve almost every case.—ED.]

TUBAL PREGNANCY.

A case of tubal pregnancy is reported by Dr. T. H. Squiers, of Elmira, N. Y., to the State Medical Society, in which rupture occurred. A large quantity of blood was removed by aspiration through the abdominal walls, followed by discharge through the vaginal wall from an opening made by a bistoury, also from the rectum, and the patient apparently nearly recovered, when unfavorable symptoms developed and abdominal section was performed, with the result of finding general adhesions which rendered the completion of the operation impossible; the wound was closed, and the patient again nearly recovered, but symptoms of blood-poisoning developed, and the patient died *nine months and four days* after the rupture of the foetal sac. The case emphasized the importance of early diagnosis, so that those remedies, such as electricity, might be used for destroying the life of the embryo, which has been recently so successfully employed.

In the course of this case the patient's temperature was several times as low as 95° F., and for a long time was sub-normal one or two degrees.

[Abdominal surgery has made such rapid strides of late that all, heretofore obscure and little appreciated cases of extra-uterine pregnancy, now become interesting to the special operators in this field. It is with pride we see our homœopathic surgeons keeping pace with the other school in this department. We shall publish in our next number several cases of the above nature.—ED.]

EDITORIAL.

ON LOCAL TREATMENT IN GYNÆCOLOGY.

Professor Pease, in his well-written article, on "Local Treatment in Gynæcology," abhors the expedient plan of treatment in Gynæcology, as now followed by our specialists, and deplors the empirical manner in which they blindly—yes carelessly, or ignorantly—resort to local treatment for abrasions (often called ulceration) of the cervix.

His theory of the chemical action of glycerine on the cellular infiltration of pelvic diseases, through its affinity for water, raises a pertinent question of the day, and will ere long help to settle, to some extent, the difficult problem of the relation of the lymphatic system to all inflammatory diseases of the pelvis. In the homœopathic school, more than any other, will this physiological and pathological question, when once settled, be of special advantage. By and through the curative range of our remedies that we know have a special relation to the lymphatic system, we can substantiate therapeutical facts, which heretofore were regarded as uncertain. We must not permit our knowledge of pathology to be traduced by a set of bigots. Show me a case of so-called, chronic uterine disease and I will show you a case of lymphadenitis; therefore, as I have often remarked to those homœopathic practitioners who actually, yet honestly, believe that pathology has no rela-

tion to our *Materia Medica* or therapeutics, "you point out to me a successful prescriber, and I will demonstrate his thorough knowledge of pathology." With a thorough understanding of our *Materia Medica* and a complete knowledge of pathology, our practitioners have a decided advantage over the Allopaths. In Gynæcology this fact is more apparent, perhaps, than in any other branch of medicine except ophthalmology and otology; the pathological conditions pointing to a group of remedies, from which by comparison or exclusion, we are enabled to select the *similia*. As our system of drug proving advances, we shall be better able to prescribe for diseases of the uterus and its appendages, and local treatment will be more and more dispensed with.

SOCIETY NOTES.

The Gynæcological Bureau of the American Institute is now complete, and the Chairman, Dr. Phillips, of Boston, has adopted, through his Secretary, Dr. Hedges, of Chicago, the following plan.

General subject for discussion: "Diagnosis and Treatment of Organic Diseases of the Uterus."

There will be five papers read on different subjects, each paper to be discussed by one member of the Bureau, as follows:

S. P. Hedges, of Chicago, Thesis: "Diseases of the Cervix Uteri." Robert Hall, of Providence, R. I., discussion of the same.

Phil Porter, of Detroit, Thesis: "Diseases of the Lymphatics." B. F. Betts, Philadelphia, will discuss the same.

H. K. Bennett, Fitchburg, Mass., Thesis: "Diseases of the Endometrium." C. B. Kenyon, Rock Island, Ill., discussion of the same.

M. T. Runnels, Kansas City, Thesis: "Malignant Diseases of the Uterus." L. L. Danforth, New York, will open the discussion.

L. A. Phillips, Boston, Thesis: "Abnormal Enlargement of the Uterus from Non-malignant Growths and Other Causes." Mrs. C. T. Canfield, Chicago, will lead the discussion of the same.

The secretary requests, in his circular, that all of the papers be prepared in as thorough and practical a manner as possible, and bear the stamp of originality. Let all of the papers be fresh ; interspersed with personal observations and clinical experience.

Each essayist will be allowed to present his own paper—in person, or an abstract, if too long. Each debater will be given five minutes to discuss the subject *assigned*.

The chairman publishes the program thus early, to give the members of the Institute an opportunity to collect clinical facts, that will be acceptable by way of discussion, and interest on the above subject when the Bureau reports next year.

SELECTIONS.

Dr. George Schloetzer, of Highland, Ill., writes us of his experience with Cocaine hydrochlorate in teething children. The application of a solution of the salt to the inflamed gums, irritated by the pressing tooth has, he says, a remarkably soothing effect, and is an efficient substitute for depletion by means of the gum lancet. Thus are the virtues of this remarkable drug being rapidly developed.

Two ladies were conversing about the late war. One said: "It is too bad that Jeff Davis is disfranchised."

"Disfranchised," the other remarked, "I did not know it; how long has he been disfranchised?"

"Why, ever since the war."

The other lady, musingly: "Well, I don't see how that can be; I am sure that Mrs. Davis has had one or two children since the war."

FOR THE COUNTRY DOCTOR.—An Englishman has devised an arrangement for driving a horse with one's feet. The feet rests on a firm board, and the horse is guided by raising or lowering the toes, thus bearing on one or other rein by means of straps in connection with them, which pass over the pulley mounted on the front board of the vehicle. The driver's hands are quite free, and may be inserted in the pockets of his great coat, or grasp firmly a hot potato.—*Med. Record.*

SHORT-STOPPS.

Metric Measures, Fluids: The French unit for liquids is the cubic centimetre (c. c.). It is equal to 16.896 minims. The following rule is easy to remember: One cubic centim. (c. c.) equals nearly 17 minims.

Jamaica Dogwood is highly eulogized for neuralgia, following uterine hæmorrhage, should be prescribed in ten drop doses of the tinct. Dr. Phillips, of Boston, also adds that it is an admirable substitute for opiates.

It is easier to make a note of a thing than to remember *where* the note was made. Therefore, every physician should have a note book, with an index heading, to copy any formula or interesting fact that he wishes for reference.

Urethral spasm relieved in the female by Cocaine: Dissolve one grain and a half of the Cocaine in an ounce of water and pass some of the solution up to the obstruction, through a catheter. In about five or seven minutes the spasm can be overcome. This treatment should apply equally as well to spasmodic stricture of the male urethra. *Cocaine* is also recommended for cystitis or an irritable bladder, to be employed as follows: Dissolve one-third of a grain of the hydrochlorate of cocaine in about four ounces of warm water, and inject into the bladder once every day.

Wens: Ether injections—Inject from five to ten drops of *pure* ether, with an ordinary hypodermic syringe daily. As the wen becomes painful and shows signs of suppuration, the injections are discontinued. The tumor is punctured at its base and the contents evacuated. In a few days the whole contents are discharged and a small lump remains.

Goitre: This pathological condition should be treated by individualization. There are five conditions to be considered. 1. Goitre may be sporadic, a local disease, without diathetic causes; *e. g.* accouchment, mechanical causes. 2. It may depend on a change of the blood; *e. g.*, scrofula. 3. Is a constituent part of the triad of signs of exophthalmus. 4. It is endemic. 5. It may be everywhere, epidemic.

Secale is more frequently indicated, not in large doses, for its dynamo-mechanical effect, but for its influence over the vascular supply, and especially in the soft, diffuse, or vascular-sanguineous form. Nothing is to be gained by the parenchymatous injection of any crude drug. Interstitial injections of *Iodine*, in the fibrous form, is still followed by the allopaths, but without success, except in cases *where Iodine was indicated*.

By giving these brief abstracts, understand us, once for all, we do not endorse or recommend them to our readers, neither do we desire to appologize for their presence in this journal, but so long as we are editor, our subscribers shall have, as is their right, condensed news on medical matters of general interest, regardless of our personal opinion or inclination.

BOOK REVIEWS.

PELVIC CELLULITIS. Mrs. M. B. Pearman, M. D., St. Louis, Mo.

This little pamphlet of 14 pp. presents in a new form some of the old ideas upon this subject which are common to various text-

books of the past, but it fails to furnish in itself any excuse for its publication, inasmuch as it is chiefly notable for the absence of any new facts, new theories or new suggestions, and for what is omitted or ignored, rather than for what it contains. No distinction or differentiation is made between a limited peri-uterine cellulitis and a general inflammation of the pelvic cellular tissue, which would include psoas, iliac and peri-rectal abscesses, although the former constitutes the vast majority of cases, while the general pelvic cellulitis is extremely rare. There is also manifest a somewhat confused idea of pelvic peritonitis and pelvic cellulitis. Among the assigned causes of the latter are found some which, while they do give rise to pelvic peritonitis, do not produce phlegmonous inflammation, and because the two conditions frequently complicate each other, therefore no distinction or differential diagnosis need be made, though they are as distinct, and no more intimately associated than pleurisy and pneumonia. The relation and influence of the lymphatic glands and vessels upon the disease and its cure, are entirely ignored and the most important remedies, such as Aconite, Iodine and the Iodides, Merc, etc., are not mentioned. If anything is added to the previously published literature of this subject, we have failed to find it in this pamphlet.—P. A. L., Philadelphia, Pa.

THE TREATMENT OF UTERINE DISPLACEMENTS, INCLUDING PROLAPSUS, ANTEVERSION, RETROVERSION, ANTEFLEXION AND RETROFLEXION.
By W. EGGERT, M. D. Second edition, with eleven illustrations. Published by Duncan Brothers, Chicago.

This little work, of 120 pages, contains, besides the authors own personal views, a paper from Dr. H. K. Bennett on "prolapsus uteri and its therapeutic treatment," read before the Massachusetts Surgical and Gynæcological society, and a paper from Dr. O. S. Saunders on "experience with remedies for prolapsus." Our remarks will not include a consideration of these papers, nor have any reference to the quotations the author so lavishly makes use of.

When a gynæcological work is contemplated, three important factors should be considered: First, *the title*; second, whether mechanical (surgical) treatment shall be included; and third, *what kind* of therapeutics shall be recommended, the empirical or homœopathic. The title of this work would deceive a majority of physicians, who order from the mere book notice. The work is one, however, that will fill a "long felt want" for a certain class of practitioners. It is one of those extreme publications that spas-

modically appear about every five years, in contradiction to another class who believe in the expectant or expedient plan of treatment. The former are the ultra high potency men, who scorn to look at, much less handle, a speculum, uterine sound, pessary, or even make use of the term gynæcology. While in marked contrast, on the other hand, the other class—equally as extreme—are simply reformed allopaths; reformed to this extent only, that they call themselves homœopathic physicians and are identified with homœopathic societies, but resort to all of the well-known, well-worn, threadbare, topical applications of the Old School. Surely there must be a middle ground for us to occupy, between these two extreme positions. The works now out do not fill that aching void, and until some “Moses” appears to lead us from the bondage of egotism and fanaticism, we must be content to rely wholly on our individual judgment in consulting authority on diseases of women.

There are two distinct departments within this special practice, that must be recognized; the mechanical and therapeutical. The former should equal in every particular, any allopathic work, while the latter should be arranged and presented upon the genuine homœopathic principles of therapeutics. We have on the market, too many of these “to tickle the fancy of a few” books that compel the authors to devote one-half of their introduction to apologies for their publication. The author makes use of the obsolete term “ulceration of the cervix,” a word too antiquated for even homœopathic literature.

EDITOR'S TABLE.

HEALTH OFFICER.—We are pleased to learn of the appointment of E. G. Folsom, M. D., as Health Officer, at Mt. Clemens, Mich. The Doctor is a fresh recruit to Michigan's Homœopathic ranks. We want more like him.

FROM THE FRIGID ZONE.—R. C. Markham, M. D., of Marquette, Mich., paid the editor a flying visit. The Doctor reports Homœopathy, in that locality booming and modestly adds that he married a lady graduate in medicine, for a partner in business and recently increased their capital stock to the extent of one boy. Nothing like a bracing climate. He leaves Marquette for Jackson.

OMISSION.—“Hints on the Third Stage of Labor,” by J. C. Sanders, M. D., in our July issue, should have been credited to the Indiana Institute of Homœopathy, where it was read May 19th, '85.

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NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal, should be exclusively for its pages; no others desired.
2. Illustrations required for original contributions, will be furnished at the expense of the journal.
3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
4. Personal controversies, not being of interest to the profession in general, can not be published. Explanations may be made through the editor. This rule will be strictly adhered to.

PATHOLOGICAL SIGNIFICANCE OF PUERPERAL DISEASES.

O. S. RUNNELS, M. D., Indianapolis, Ind.*

Reproduction was ordained of God. It was not an after-thought, and it was not brought in by way of appendix or as one of the errata of the work. It was in the original design of things. Every wheel of its machinery, every capability of its exercise, and every provision for its successful performance was carefully planned for and provided. Together with all the other works of the universe this passed the critical review of its Great Maker, and being pronounced "very good," was set in its own place to do its perfect work. Like the stars in their orbits it was designed to take its way among the forces of the creation without clash or interruption--without impairment or catastrophe.

*Read before the Indiana Institute of Homœopathy, May 20, 1884.

Its mission among all plants and animals alike was the perpetuation of the species; and that it was designedly loaded with penalty and disorganization in any single department of its service all analogy goes to disprove.

All this may sound either trite or strange; but it is not too hackneyed to reiterate, and it is not too grotesque to be true. It is filled with matter of greatest importance to the human race. It has in it the germs of immense suggestion. It contains a lesson we can well afford to dwell upon and learn. For, however familiar this may all be to us in thought, are we alive to it in practice? The daily experience proves that practically we are not responsive to its teachings. We are proverbially inclined to shift all the responsibility, to deny our individual agency in the production of disorder, and to charge it back upon an All-wise Creator as a somehow "mysterious providence."

Why, during all these generations, such a blind and foolish course has been pursued; why men have not perceived that their "ills" and "accidents" are earth-born, mostly self-generated, and why they have not utilized this knowledge in ending the most of the affliction and premature death that they do now per force meet, is a conundrum I shall leave others to answer. It is only pertinent for us here to again make statement and study of this problem of self-preservation; to do our share in hastening the advent of that possible time when blasting and premature decay shall be unknown; when death shall come as it should to those only in mature age and life-ripeness, and when the generative function shall be relieved of its present unnecessary burden of difficulty, disease and death.

I have said that in all nature the human family was the solitary instance of reproductive embarrassments; that nowhere else in any kingdom or genus could such generative deviations be shown, and that it was reserved for man, the wisest, and in some respects the blindest and basest of all created objects, to falsify the record and to persist in the

face of knowledge in the continuance of destructive practices.

Let us see if it be not so. Among the plants there is a universal observance of the divine order. Fertility, mature life, vigor, rotundity, beauty, seed-time and harvest do not fail. They are as certain as the sunrise. Here there is no tampering with the commands; there is no attempted evasion of the precepts. Among the dumb animals it is equally true. Sterility, blasted ova, death in utero and inability to cope with the life conditions are, in all the lower orders, unknown. Such a thing down there as an offspring without mother-wit or instinct enough to conduct its little affairs is not enumerated. There is perfect endowment in form and function to the full limit of the original design. Nor can we note any disposition in any of these animals to voluntarily deviate from the line of action prescribed for them. The life demands are all judiciously observed, and it is refreshing to witness that they know what is for their own good. It is remarkable, also, that the rights of the unborn are respected! No riotous and gluttonous expression of what we are pleased to misterm the "animal passions" is apparent. Sexual congress is employed, as it was intended, only for the propagation and perpetuation of the species.

Such an atrocity as intercourse *out of season* is nowhere seen. Although they lead the community life—the males and females having a promiscuous belonging—gestation and lactation are regarded as periods of sanctity—are pre-empted for the important function of reproduction. So far as we can see, no brute thinks of such a thing as claiming the female for his sexual gratification at such a time! Nor is he ever disrespectful of the inclinations and wishes of the female. The common practice of raping the female—so familiar in the human branch of the kingdom—is here neither legalized nor permitted, and the sick and the indisposed are allowed to find sexual rest. In short the amen-

ities and proprieties of sexual life *are regarded*. The consequence is that the female is permitted to expend all her powers in the accomplishment of a perfect work. Inasmuch as she is not a bankrupt in sexual force she is able to discharge her mission creditably, both as to herself and her production. Maternity with her is *not loaded with penalty* and her offspring is a perfect reproduction.

Her parturition is a matter of ease and although performed usually under what may be termed "bad sanitary conditions," with millions of the dreaded bacteria and septic germs about her, in cold and heat, in storm and sunshine, and without aid of accoucheur or listerism, her puerperal experiences are not to be dreaded! Neither does she find it physically expensive to be a mother. The wear and tear of mother-hood of which we hear so much is with her a nonentity. With perfect organs in harmonious exercise she finds the reproduction of her kind filled only with the best blessings that her frame can know.

But all this is not as we know it among civilized men! Here the vision changes! A long catalogue of ills and "accidents" is presented, and we are amazed at the burden of difficulty which rests upon human maternity. Coming from the contemplation of universally perfect work we are filled with wonder at so vast a discord, and the everlasting *why* presses for answer.

Unfortunately we do not have to search long for the reasons. Standing behind the scenes as it is our province as physicians to do, we have come into possession of facts which can no longer be considered as "professional secrets" and which must be laid open as the day so that all who run may read. The sexual history through a few generations tells the story. It is the record of the penalties of sexual misdemeanors and crimes crystalized into defects either in the perpetrator or his progeny with which we have to do. Whatever else may enter as factors in the mal-performance of sexual function, the effects of the vol-

untary transgressions of the sexual law will still hold the chief place. Starting with the individual at the dawn of sexual consciousness, we see ignorance as the only guide leading the imagination by way of lewd pictures, lascivious conversation and prurient love-stories, through masturbation to puberty; with the sexual organs thus in a state of long-lasting hyperæmia, congestion and erection, the vacillations of sexual conduct are manifest; the lapses from the line of rectitude are rendered more frequent and the sins against gender, both solitary and associated, are ever more and more pronounced.

Through the long-lasting and burning desire for sexual gratification for its own sake, and the fixed determination and endeavor to avoid the consequences of normal indulgence, the participators are ever more detracting from their primal powers of perfect self-hood. In the incipient loss of manhood and womanhood they have already laid the train that must eventuate disastrously. Every solitary endeavor to produce sexual excitement and orgasm; every incomplete copulation is a fraud upon the God resident in us and verily shall have its reward. Every involuntary or menstruating female that is subjected to copulation has been raped and robbed of her prerogative.

Going no farther, enough has been enumerated to dwarf the sexual function and environ it with difficulty. These misdemeanors followed for a generation or two must inevitably condemn maternity to troublous experiences. Supplement these now with venereal disorders and the effects of the wanton crime of fœticide, and puerperal damnation is assured.

It is all well enough to talk learnedly about bacteria and micro-organisms of whatever type as being the causes of puerperal diseases. That sepsis has much to do as provoking cause in all these conditions we do most earnestly believe, but that they fill all the requirements of provocation and induction we will not admit.

There are no more "germs" in these days of soap and water—of greatest sanitary precaution--than there have ever been. They do not swarm around the parturient female in civilized life more than they do around the mothers of animals and the lower human races.

But the animals and the primitive women, and the women of refinement who have been allowed to keep the commandments of generative truthfulness for a sufficient time, are blessed with immunity! No; the germ is not enough. It is only when an individual is vulnerable at some point that he succumbs to the incursions of disease. It is only when the wall of defense has been broken down that the enemy can scale it. Disease and incompetence of function proves that the wall has been broken down.

ANÆSTHETICS IN NORMAL LABOR.*

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I shall not attempt, in the brief time allotted to me, to give you a thorough and exhaustive treatment of this subject; but will simply give you a few thoughts, suggested by a somewhat extensive reading and a limited experience.

The question as to the necessity and usefulness of anæsthetics, in abnormal cases of labor, has long been settled. Although there is some difference of opinion as to the frequency of their necessity and the conditions that call for their use, yet the profession have agreed that they are both necessary and beneficial in certain abnormal conditions.

The object of this paper is to bring before this society for a free and fair discussion the question asked by many a sincere and learned physician of the present day, viz: Are anæsthetics useful in normal cases of labor? By normal

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labors, I mean those cases that are uncomplicated; such cases as we usually meet, and not in the sense that some employ the term normal, meaning painless labor. To this question I answer, yes, most emphatically, yes; but on this point, I am aware that for one reason or another some will differ from me in opinion. And yet, I am also confident, that if you could be persuaded that there was no danger in their use, every one of you would employ them. I will even go one step farther and assert that if you believed the benefit obtained would be commensurate with the risk which you claim must be incurred, you would relieve the pains of child-birth with them. That it is a dangerous substance when improperly employed all must admit. But because an article is dangerous when thus used is no argument against its employment by skillful operators at proper times and places. As a rule, the more dangerous a weapon the more potent.

Let us first consider the reasons given why anæsthetics should not be used in normal labor, and afterwards the reasons why they should. The reasons given against their use are two:

1st, They have a tendency to cause death when there is disease of the heart or lungs.

2nd, They cause death from post-partum hæmorrhages, by relaxing the tissues of the uterus.

Concerning the first statement I will say but little at this point. If there exists any serious lesion of these organs, it is a valid reason why they should not be used; or, if used, only with the utmost caution. But as every educated physician has it in his power to ascertain the existence of such lesions, these cases can only form the exceptions to the rule. Who would say that anæsthetics should not be given for capital operations because some one had died from the carelessness of some physicians who had failed to examine the heart and lungs?

In regard to the second reason, you may say that no phy-

sician can foretell a case of post-partum hæmorrhage, and therefore I cannot do away with the second as I did with the first objection.

True, but the first objection given was a real one, the second is only a bugbear. I have asked at least forty physicians, within the past six months, if, in their experience, or from personal knowledge they could give me one case where anæsthetics caused death from post-partum hæmorrhage. Every one has answered; "no." I have also examined every work on this subject I could obtain, and if such a case has ever occurred it has never, to my knowledge, found its way into print. Some of these physicians, with whom I have talked, have heard of cases where there was severe flooding and death as the result; while in other instances this terrible accident "almost happened" in their own experience. They however, had the good luck to check the flow just in time to save the patient's life. On this subject I wish to give the experience of one of our best obstetricians. Prof. S. Leavitt says: "In the Hahnemann hospital it is our custom as a preliminary to the introduction of the class of students, to bring the woman profoundly under the influence of chloroform, and though unconsciousness is frequently maintained for a period of from one and a half or two hours, among the hundreds of women confined there during the past few years, not a single case of alarming hæmorrhage has been met." A case came under my own observation last summer in which the woman, a primipara of forty-four was kept under the influence of chloroform, most of the time completely, for over three hours without a single unfavorable symptom appearing in either mother or child.

H. M. Lyman has collected in Wood's Library for 1881 the reports of all cases of death caused by ether or chloroform. Of over 430 cases there collected, in only six did death take place during labor, and in not a single instance was there any mention of hæmorrhage. In fact, in only one

case did death take place after the birth of the child, and in that case the record reads that the woman died while the uterus was contracting.

Let us examine these six cases and see what lessons may be learned from them.

*Case 57.**—"A lady, during the early stage of labor, in the care of a nurse, her physician being absent, inhaled about five drachms of chloroform from a handkerchief, went to sleep, and was found dead and cold, when the nurse, who had also fallen asleep, awoke."

Case 79.—"Patient, married, sixth time pregnant; had taken chloroform at each confinement. Sept. 20th, 1858 her pains commenced at 2 A. M. No one but a nurse was in attendance. About 20 minutes to 8 A. M., expulsive pains came on, when she called for chloroform. After breathing it a few times from a handkerchief she threw herself violently back, gave a gasp or two, a slight gurgle was heard from her throat, and respiration and the pulse instantly ceased. Her physician arrived on the spot ten minutes later, and found her dead."

Case 80.—"In a letter, dated Nov. 15th, 1858, Dr. Duncan states that he was called to a case of confinement, in which, on arrival he found that the patient had suddenly died while inhaling a small quantity of chloroform during the pains of labor."

Case 327.—"Patient, twenty-five, entered the maternite at Lyons, March 23d, 1876. Labor pains continued during the evening and night. The next morning at seven o'clock the membranes ruptured, shoulder presentation. To facilitate version chloroform was given by the nurse without calling upon the attending physicians. The patient did not arouse after the operation. The house physician was then called who found the pulse very small, the face cyanotic,

*Numbered as in Wood's Library.

the respiration short and frequent. In spite of efforts to the contrary the patient died in ten minutes."

Case 328.—"Patient, 22 years, primipara. The head of the child was at the point of birth, when a slight convulsion occurred. Chloroform was given and the patient was kept under its influence. After the delivery of the head, while the uterus was contracting, the patient shuddered and her pulse ceased. She was dead.

Case 393.—"Primipara, age 36. In good health. Had been unusually well during pregnancy, kidneys healthy, urinary secretions normal. Had been in labor eight hours. The severity of the pains caused her to insist on chloroform, and finally the physician allowed her to inhale intermittingly, a few drops at a time on a handkerchief. She did not become unconscious, and at the end of ten minutes began to complain of a sense of thoracic oppression and dyspnoea, desiring to be raised to a sitting posture. She was thus raised up and at once the neck and face became livid. The patient was at once placed in a horizontal, but had already become unconscious. She frothed slightly at the mouth, the cheeks were blown out in expiration and after half a dozen sighing respirations, at increasing intervals she ceased to breathe." Although these cases do not teach that hæmorrhage is the great danger that results from the use of anæsthetics, they do teach some very plain truths.

1st. In the first place they most emphatically teach that no woman should administer them to herself, and also that none but those versed in their use should ever employ them. In four of the six cases the attending physician was not present when they were given. In three cases he did not arrive till after the woman was dead.

2nd. They teach that to saturate a handkerchief or cloth of any kind with chloroform and spread it over the patient's nose and mouth is a dangerous practice. The chloroform escapes into the room, affects the attendants and vitiates the

atmosphere. In the first case the nurse was influenced by it, went to sleep, and when she awoke found her patient dead. I shall speak farther on this point later.

3rd. Examination of the heart and lungs should be made in every case previous to the time of confinement. If not, it should be done at that time before giving the chloroform.

The reasons why anæsthetics should be employed are the following:

1st. To mitigate pain.

That they do mitigate if not entirely annul pain, even when other means fail, is the universal testimony of both the women and physicians who use them, and as it is one of the first duties of the physician to relieve suffering when he can with comparative safety to his patient, this alone, should be a sufficient reason for their use.

2nd. They save nerve force and promote a speedier recovery. There is nothing more prostrating to the nervous system than the acute and prolonged pain of labor, and when the labor pains are unusually severe the woman is generally restless between them. By giving an anæsthetic the severity of the pains can be entirely subdued or at least greatly mitigated and the patient allowed to rest between them. As a result the greater part of the strength, otherwise expended, is saved and our recoveries are more satisfactory.

On this point I will quote T. Gaillard Thomas. He says: "The rule should be to employ an anæsthetic in every case of labor, during the second stage, unless some contra-indication exists. After a delivery under its influence patients recover more rapidly, are freer from complications, and show fewer signs of prostration."

3rd. They will prevent the destruction of a large number of embryonic lives. There is no avoiding the fact that dread of pain during child-birth has, in numberless instances, led the pregnant woman to produce abortion. There is not a physician of five years practice who has not been

consulted on this very point. And when you have refused they have gone elsewhere as future observations have proven. Had such a woman's previous labors been made painless by an anæsthetic this disgrace would never have befallen a respectable family. I say respectable because those who are not, go at once to the professional abortionist and never consult a physician of good reputation for this purpose.

4th. The fourth, and, to my mind, the most important reason is the effect that the looking forward to a painless labor will have upon the child in utero. Why do we as physicians say to the woman who has become pregnant. "Don't withdraw at once from society, keep in the open air and sunshine as much as possible. Do not give up those pursuits that you have previously enjoyed, but keep the mind so busy with light and cheerful employments that all thoughts of the future event will be crowded out?" Why do we say to the friends "Avoid all that will irritate, gratify her whims, do all that you can to keep up her spirits so that she may look forward to labor, if not cheerfully, at least without dread?" Why do we give this advice? Is it entirely for the mother's benefit. That of itself would be a sufficient reason; but we all know that the child's mental characteristics which are being formed at this time and which will continue for life, is the real reason. All abnormal conditions of the mother's mind due to gestation usually disappear after parturition, but the impressions stamped upon the child's mind by these conditions are life-long in their influences. Now if the first labor was prolonged and very painful, as the first labor usually is, what will be the result? The woman will live in constant dread of again becoming pregnant, and after conception has taken place the recollection of the past and the prospect of a repetition of the same experience in the future make her wretched. In some cases these gloomy thoughts work upon the mind until she reaches that state that she wishes the child within her dead, or as I have had one tell me, "I have gone to sleep

many a night feeling so despondent that I wished I never would wake up again." To such a one the husband says "Cheer up," the mother says "Cheer up," the first confinement is always the most painful."

Some kind (?) neighbor comes in and says "Cheer up, if you do not your child will be born and grown up a gloomy, ill-humored, taciturn morose man or woman and perhaps with an inherited disposition to commit suicide or murder. You know we read of such things and most doctors believe them. So for your child's sake, if not for your own, you must rouse yourself." What weight has all the advice and assurance you can give such a woman against the terrible experience through which she formerly passed? But had the first labor been made painless by an anæsthetic no such state of mind would have existed.

In summing up I want to use Dr. Naphey's words on this subject: "Is it possible to avoid the throes of labor? This is a question which science answers in the affirmative. Of late years chloroform and ether have been employed to lessen or annul the pains of child-birth with the same success that has attended their use in surgery. These agents are thus given without injury to the child, and without retarding the labor or exposing the mother to any danger. When properly employed they induce refreshing sleep, revive the drooping nervous system and expedite the delivery." Having decided to use an anæsthetic, the next question to decide will be, which shall we use, ether or chloroform? Let us bear in mind that the object is not to produce complete unconsciousness, but simply to annul pain.

For this reason chloroform is the more desirable for the following reasons:

- 1st. It causes the greatest loss of sensibility in proportion to the amount of narcotism produced.
- 2nd. It is more uniform and reliable in its action than ether.
- 3rd. It produces the desired effect more rapidly.

4th. The patient recovers from its influence in shorter time.

5th. It is not as liable to produce nausea and vomiting.

6th. It is safe and at the same time possesses the above advantages.

Statistics show that for complete and long continued anæsthesia ether has a better record than chloroform. But in obstetrics the case is different. Instead of being worn out by disease, as is usually the case with those on whom operations are required, the patient is generally in the prime of life and good health. The anæsthetic is administered while the patient is in a recumbent position, so that the heart's work is lessened. The pains cause an increased flow of blood to the brain, thereby preventing death from anæmia of that organ. The mind is so occupied with the general excitement of the occasion that the anxiety and fear which, in so many cases, work upon the nervous system and causes death, are also avoided. Experience teaches that for these and other reasons chloroform, for our purpose, is equally as safe as ether. The mixture of one part of turpentine and nine parts of chloroform is highly recommended by some physicians. The turpentine causes a freer and more complete aeration of the lungs. Many physicians advocate and use a mixture of chloroform and ether, but as Homœopathists do not believe in mixing drugs, it is unnecessary to give the reasons why a pure article of either is better than a mixture.

During what stage of labor shall we use our anæsthetic? On this point we again find our authors at variance. Some prohibit its use during the first stage; others advise the alleviation of pain whether in the first or second stage. As some of our sensitive and nervous women really suffer more from the piercing, cutting and, what they call, "unbearable" pains, caused by the dilatation of the os than from the expulsive pains of the second stage, and as has been before stated, the object is to mitigate pain, chloroform should be given, to that extent, during both stages.

How should chloroform be administered? Whether or not the patient has gone to bed it should never be given in any other than the recumbent position. If the pains come with regularity and at long intervals, the patient may be allowed to walk about soon after each pain; but if frequent and irregular it is best to keep the patient in the recumbent position.

Chloroform should be administered in a cone so constructed that if the assistant becomes interested in something else and permits the cone to drop over the mouth and nose the patient may still obtain a sufficient quantity of air. A napkin or handkerchief that may be spread or permitted to fall over the face so as to prevent a free passage of air should never be employed. Of the one hundred and eighty-five cases of deaths in which the mode of administration was stated, napkins, towels, etc., were used in one hundred and thirty-nine cases.

The cone should be so made that when it is not in use it may be placed upon the bed or a pillow and prevent the chloroform from escaping into the room. Only a small quantity should be put upon the cone at a time.

The clothing about the neck and waist should be loosened. If at any time nausea and vomiting should occur, a dose of *Nux vom.*, or a few inhalations of vinegar, which is easily obtained, will generally control it. Most of our writers advise giving the chloroform during the pains, but this I think is a mistake. During the pains, especially the expulsive, the act of respiration is interfered with to such an extent that the chloroform does not enter the lungs in sufficient quantity to produce the desired effect. For this reason chloroform should be exhibited just before the pains. To antidote the bad effects of chloroform the usual means should be employed, viz.: electricity, artificial respiration, aqua ammonia, amyl nitrite, etc., etc. I will close by saying that I sincerely believe it the duty of every physician to relieve the pains of child-birth by an anæsthetic in every

case except where it is clearly contra-indicated, for the reasons given above, and I hope that our school, which is ever foremost in using all the means that Providence has given us to relieve the sufferings of the human race, will not be derelict in this especial duty.

THE MANAGEMENT OF ABORTION.

Prof. L. L. Danforth, M. D., in a paper published by the *American Homœopathist*, gives an important summary of the treatment of these cases. As remedies for abortion, which is threatening, he cites, "*Aconite*, when fear or fright is an element in the production of the symptoms. This remedy is useful at any time during pregnancy, but is more apt to be indicated in the earlier months. Restlessness and fear of death, or general apprehensiveness, are especially characteristic symptoms. *Opium* also is useful where fright is the cause, but the mental state is entirely different from that of *aconite*. The value of *Arnica* cannot be over-estimated when the symptoms of threatened abortion are due to falls, injuries, shocks, etc., or *Rhus tox.* when from strain or over-exertion. *Sabina* is useful in nervous, hysterical women when the discharge is bright red, partly clotted blood; worse from motion, pain from sacrum to pubes, *Ipecac*, *Bell.*, *Puls.*, *CaULO*, are very important in their several places, and their indications are so well known I need not dwell upon them. *Viburnum prunifolium* is a remedy of great value, and its merits are recognized by all schools of medicine. It is said to be particularly valuable in preventing abortion or miscarriage, whether habitual or otherwise, whether threatened from accidental causes or criminal drugging. It tones up the system, preventing or removing those harassing nervous symptoms that so often torment, wear down and disqualify the pregnant woman for the parturient effort. In addition to the remedies indicated, rest in bed is

the first thing to be insisted upon, and should be continued until all danger is over."

In cases where abortion is inevitable Prof. Danforth gives "three results which it is desirable to accomplish, viz., *the relief of pain, limitation of hæmorrhage within the smallest possible amount and the complete emptying of the uterus.*"

He emphasizes the fact that, though early abortions frequently occur without the nature of the real condition being suspected, they are not absolutely devoid of danger." In his opinion the reason that cases of criminal abortion are so much worse than others "is due to the fact that nature's aid is not invoked in the expulsive process. Whatever means employed in the production of criminal abortion, the membranes only are punctured, or sufficient irritation only is produced to originate contractions of a moderate degree of intensity, and these rupture the membranes, discharge foetus and liquor Amnii, while the secundines are retained or become subsequently discharged, or form the nidus of infection or secondary hæmorrhages."

In the relief of pain in a case of abortion, the author gives us the following: "The remedies most useful are Belladonna, Caulophyllum, Chamomilla, Gelsemium, Sabina, and the Viburnum prunifolium already mentioned; each one being administered according to the characteristic symptoms so well known to all. The tincture of opium (tr. opii deodorata) is often of great service, even in small doses, in relieving pain and subduing general nerve irritability. It may be given in doses of three to five drops often repeated, or in doses of fifteen or twenty drops less often administered, until the pain disappears. The recommendation of this remedy in the doses mentioned, will no doubt be considered rank heresy by some physicians of our school, but I can see no reason why it should not be given in those occasional cases where the pain is intense and there is no immediate prospect of a subsidence, unless it is obtained by the resources of art.

“The effect of Opium is often beneficial in two ways; as already mentioned, it lessens the irritability of the uterus and of the whole nervous system, and if the separation of the ovum has not progressed too far, it has the power to check the entire process; or, if on the other hand, the abortion is inevitable and the pain incident to dilatation of the cervix excessive the remedy will relieve the latter at the same time that it favors the dilatation, and then after due time, the patient having been comfortable the meanwhile, the foetus is found in the cervix ready to be expelled or removed.”

For the relief of hæmorrhage measures must be taken at once to produce a diminution of the flow. Prof. Danforth recommends as medicines useful in controlling hæmorrhage: “Belladonna, Cinnamon, Crocus, Ipecac, Sabina, Millefolium, Trillium and Erigeron.” As to the use of the tampon he gives the following:

“When the hæmorrhage becomes excessive, and there is no prospect that the uterus will speedily empty itself, we must resort to positive means to check the loss of blood. The tampon here finds its greatest field of usefulness. This may be employed merely to check hæmorrhage, hoping that thereby the other alarming features will disappear and the case go on to recovery; or if the abortion is really unavoidable the employment of the tampon may be coupled with the use of the sponge tent. The latter should first be placed in the canal of the cervix and just through the internal os; as it swells and dilates the passage it also proves an effectual barrier to the discharge of blood, thus acting as a hæmostatic measure of great value. The cotton tampon should next be placed against the cervix, and round about it, in the anterior and posterior spaces, thoroughly packing the upper portion of the vagina. (The tampon is best made of small pieces of cotton as large as a butternut, and tied at intervals of a couple of inches upon a piece of stout twine, the end of the latter hanging out of the vagina to facilitate re-

moval). It is impossible to place a tampon so that it will perfectly answer its design without the aid of a Sims's speculum.

"The operation can be done with an ordinary bivalve instrument, but not nearly so well as with the Sims's. If the cotton is not compactly placed in the vagina the operation will be of little value, since the blood will surely ooze past a carelessly applied tampon. The sponge tent referred to is not an indispensable requisite in the management of these cases, but when at hand it certainly affords additional security against hæmorrhage. The tampon may be left in the vagina from six to eight hours, and after removal, re-applied if necessary. The foetus and secundines will often be found in the cervix, ready for removal after a single application of the tampon."

In discussing those troublesome cases of miscarriage in which the ovum is cast off and the placenta retained, with the two diametrically opposed opinions held by physicians at the present time with respect to the management of these cases, the writer gives the rules which guide him as these: "When the ovum has been cast off, with retention of the secundines and closure of the cervix, it is perfectly safe to administer either China, Caulophyllum or Pulsatilla, as may seem indicated, at same time that the patient is kept under close surveillance. Should hæmorrhage co-exist with retention of any portion of the secundines, the remedy and the tampon may be used together. I do not believe in re-applying the tampon several times; if the cervix is not open and the placental tissue ready to come away; while hæmorrhage continues, it is better to dilate the cervix and use the curette, to thoroughly empty the uterus at once. I have employed the curette a great many times and never have had occasion to regret the practice. On the contrary, I am sure I have saved many patients from the danger of hæmorrhage and septic infection by so doing. In the hands of one accustomed to the employment of instruments in the cavity

of the pelvis, and within the uterus, the curette is a perfectly safe and beneficent instrument. More than once have I seen a woman relieved of a sharp chill, followed by rigors and a high fever, by removing from the uterus with a curette a small fragment of placental tissue. More than once have I seen a woman who had flowed for weeks until she had become unfit for the duties of life, entirely relieved by the removal from the uterus of placental tissue which had formed into a polypoid mass. These untoward results may all be obviated by the adoption of the more active plan of treatment which by all odds, in my opinion, is the wiser one. Not that all women who are treated on the expectant plan suffer the dire results I have mentioned; but now and then one unquestionably does, and it is our bounden duty to so practice our art that not a single individual suffers unnecessarily. While I do occasionally wait upon nature's efforts to rid the uterus of its contents, as indicated above, and do give the remedy that will facilitate the removal of the mass, I never feel safe until I am sure that all has come away. On the first indication of a chill or rise in temperature, or should the discharge become offensive, the curette is used. My more common practice is to cautiously use the curette at once if bleeding continues and I have reason to suspect that all has not been thrown off. I am not sure until I have done this that the woman is safe from future trouble. I believe fully in the following extract from a paper by Dr. Paul F. Munde, published in the *American Journal of Obstetrics* for 1883, and I believe it should be the axiom of practice for all physicians. He says: "I wish to add my testimony in favor of the forcible (that is, manual and instrumental) removal of the secundines immediately after the expulsion of the foetus, in every case where the cervical canal is sufficiently patulous to permit the introduction of the finger or of the large dull curette or the placenta forceps. Further, if there is hæmorrhage, or an offensive vaginal discharge, or if the temperature rises, or there is a

chill, and the secundines are still retained, no matter how soon or how late after the expulsion of the foetus, they should be at once removed, and if necessary, the cervix dilated to facilitate the operation."

THE RELIEF OF PYLORIC STENOSIS.

Until within the past six years the above condition was regarded as beyond the domain of surgical interference, and with the diagnosis, stenosis of the pylorus, the fate of the patient was irrevocably sealed. Internal medicine offers absolutely no hope to the unfortunate sufferer from pyloric stenosis, until Péan, in 1879, performed pylorotomy for the relief of pyloric disease, and ushered in a new era in abdominal surgery. Dr. Randolph Winslow, of Baltimore, in *The American Journal of the Medical Sciences* for April, 1885, has collected and analyzed all the recorded cases, eighty-five in number, of operative interference for the relief of pyloric disease. He presents the following valuable deductions: 1. In cancer of stomach not producing stenosis, anodynes should be given in quantities sufficient to relieve distress, and no operation should be performed. 2. Pylorotomy for carcinoma is followed by seventy-six per cent. mortality, hence it should only be very exceptionally performed in those cases where, with marked stenosis, the pylorus is not adherent to the neighboring organs, and the patient is young and fairly strong. 3. In other cases of carcinomatous stenosis, as only temporary benefit can be obtained, gastro-enterostomy should be performed. 4. In cicatricial stenosis digital divulsion should be performed, but if this is impossible owing to great thickening of the walls, resection in those who are well nourished, and gastro-enterostomy in the debilitated will both be followed by good results. 5. Hæmorrhage or perforation from ulcer or other cause than stenosis, does not present indications for pylorotomy. 6. Duodenostomy, gastrostomy for the passage of a tube, and complete gastrectomy should be replaced by gastro-enterostomy. In the same journal Dr. J. M. Spear, of Cumberland, Md., reports a case of partial pylorotomy in a blacksmith, aged forty, who suffered from cicatricial stenosis of the pylorus. The operation was a modification of Billroth's, and required one hour and a half for its performance. The tumor was not adherent. Death ensued in two and a half hours, from collapse. In the opinion of Dr. Spear the case was an eminently proper one for operation, but it should

have been performed at an earlier period in its history.—*Medical Record*.

The editor enjoyed the pleasure of witnessing some of Billroth's operations for relief of cancer of the pylorus, but Dr. Wolfier—Billroth's first assistant—had the satisfaction of recording the first successful case of resection of the pylorus for carcinoma. This operation, like all innovations in abdominal surgery, meets with opposition from those who are not familiar with the different steps, and wish to bray their superiority (?) of surgical knowledge by condemning an operation that may yet prove as much of a boon to suffering humanity as any advanced surgical procedure. Any operation that affords *relief* to a patient, even if temporary, is justifiable.

One case of cancer of the stomach upon which we saw Prof. Billroth operate when the carcinomatous infiltration was too extensive to permit of a resection of the pylorus; he created an artificial fistula between the greater curvature of the stomach and the posterior wall of the duodenum, to permit the patient's food to pass directly out of the stomach into the duodenum, without producing any irritation at the diseased portion of the stomach, which was always followed by distressing vomiting. This man lived some months and expressed his gratitude for the relief from vomiting. There are yet many interesting developments, in abdominal surgery, awaiting cultivation by the surgeon.

VAGINAL HYSTERECTOMY FOR CANCER.

At the recent meeting of the American Medical Association, Dr. A. Reeves Jackson, of Chicago, read on this subject, basing his conclusions upon the results in 256 cases as compiled by Dr. Paul F. Munde, and in 201 cases as reported by Schroeder and Olshausen. A mortality of 24.6 per cent. in the 256 by Munde, he claims, is too small, as the cases were "picked," some of the unsuccessful being

suppressed. The mortality reported by Schroeder and Olshausen is 38.6 per cent. His conclusions are:

(1) Any operation for cancer, which does not completely remove the disease, will be followed by recurrence.

(2) During life, the diagnosis of the extent of cancerous disease originating in any part of the uterus is at present impossible; hence, no operative procedure can afford a guarantee of complete removal.

(3) In view of this necessary doubt, no operation is justifiable which greatly endangers life, provided other and safer methods of treatment are available.

(4) Vaginal hysterectomy has sacrificed the lives of more than one-third of those who have been subjected to it; the mortality of the operation, when done by those of greatest skill and experience, being over 36 per cent.

(5) Other methods of treatment, attended by not more than one-sixth to one-fourth the mortality of vaginal extirpation, are equally efficient in ameliorating the symptoms and retarding the progress of the disease, and these have been followed by as good, or better, ultimate results; hence, they should be preferred.

(6) Hysterectomy does not avert or lessen suffering; it destroys, and does not save life. It is, therefore, not a useful, but an injurious operation, and, being such, it is unjustifiable, and ought to be abandoned.

As opposed to these objections of Dr. Jackson, Dr. Munde contends that there is a field of usefulness for vaginal hysterectomy for the following reasons: The percentage of mortality is constantly decreasing, as the experience of operators increases, and as they select cases favorable for operation, as proven by the recent report of twenty-four operations by Feitch, with only two deaths. In estimating the percentage of recurrence, at Munde's time of writing, only eighty-two cases were available, two years having elapsed since operation. Of these 39.2 per cent. remained free from recurrence; while, from removal of the

cervix alone, the percentage is only 25, and from various other methods it is only 21.8 per cent.

These eighty-two are among the earlier cases operated upon; hence, the percentage of recurrence would naturally be greater than in those better selected. In those cases where there is recurrence after hysterectomy, the amount of suffering is much less than before the operation, and without the same hæmorrhage, as attested by the observations of many operators.

[Hysterectomy, or better known as hysterotomy, like all abdominal operations, must pass through the same ordeal of professional doubt and bitter denunciation before it will become a recognized surgical procedure in grave diseases like cancer, fibro-cystic tumor or any neoplasm that endangers life by uncontrollable hæmorrhage, when the patient is young or some distance from the climacteric period. The vaginal method will never "be acceptable, but as a *dernier ressort*, to avoid opening the abdomen, will for a time, have some advocates.

We fully appreciate Dr. Munde's remarks in the above discussion, that the operators' *experience*, not *theory*, is one of the prime factors in the rate of mortality. This branch of surgery—abdominal operations—will, ere long, be given its proper position in the mechanical part of medicine.]

P. P.

PROVING ONOSMODIUM VIRGINIANUM.

Dr. W. E. Green, of Little Rock, Arkansas, sends us an interesting proving of the above plant. We give a brief abstract of its action on the female sexual organs, so far as recorded.

The prover, Mrs. C——, commenced taking one teaspoonful of the tincture every three hours, until four doses were taken each day. The following is a condensed report:

FEMALE SEXUAL ORGANS.—SEVERE UTERINE PAINS.
BEARING-DOWN PAINS IN THE UTERINE REGION. *Uterine*

cramps "like those produced by taking cold during menstruation." Soreness in uterine region increased by external pressure, and by the pressure of the clothing; had to remove the corset. Old uterine and ovarian pains that had not been felt for years re-excited. Dull, heavy, aching, and slowly pulsating pains in the ovaries. Pains begin in one ovary and then pass over to the other, leaving a soreness that lasts until the pains return. Severe pain in the ovaries, increased by pressure. Old ovarian and uterine pains, at first entirely relieved, subsequently greatly aggravated. Sexual desire completely destroyed. Uterine pains better when undressed and when lying upon the back. Constant feeling as though the menses would appear. Menstruation, natural in character, appeared four days early, and lasted too long. The next two menstrual periods were anticipating and profuse. Light yellowish, slightly offensive and excoriating, leucorrhœa; profuse, running down the legs. Itching of the vulva, aggravated by scratching, and by contact of the leucorrhœal discharge.

BREASTS.—Aching in the breast, worse in the left. Both breasts feel swollen and engorged. Left breast feels bruised and is painful upon pressure. Itching about the nipple.

HEART AND PULSE.—HEART'S ACTION AT FIRST INCREASED to 90 beats per minute; PULSE FULL AND STRONG, within one hour it dropped down to 60; pulse soft. PULSE SLOW, WEAK, AND IRREGULAR. *With every third or fourth pulsation the diastole is prolonged almost to intermittence.* Pain in the region of the apex of the heart. Constant feeling of oppression about the heart. Cannot lie upon the left side. Heart disturbance excites apprehensions lest she will die.

NECK AND BACK.—*Pain in the neck, running back from the forehead. Dull aching pain in the neck. Pain in the back very low down. Pain in the small of the back on awakening in the morning, passing away about noon. Bearing-down pains in the lumbar region. Dull, aching pain in the lumbar region.*

NOTES.

L. A. PHILLIPS, M. D., Boston, Mass.

That no definite knowledge of the cause or reason of menstruation yet exists is made evident by the frequent attempts at an explanation of the phenomenon; no general agreement existing among the writers upon the subject. The exact relation of ovulation to menstruation is yet to be demonstrated, for while they are generally considered inter-dependent it has proved and demonstrated that ovulation occurs both before and after the existence of the menstrual function.

In a study of this subject published in the Albany Medical Annals, Dr. Franklin Townsend concludes "that menstruation should be regarded as an incidental rather than an essential function. That ovulation does occur independent of menstruation. That menstruation can occur independent of ovulation, and that the flow after complete extirpation of both ovaries and tubes, is not true menstruation, but a metrostaxis." "A New Interpretation of the Menstrual Process" is presented by Loewenthal, through the *Archiv für Gynäkologie*, Vol. xxiv. Abt. 2.

From a careful consideration of the periodicity, nature and duration of the flow, the quality of the blood and the anatomical and histological alterations of the mucous membrane of the uterus, he concludes that the menstrual process consists of three divisions, viz: (1) Growth or swelling of the mucous membrane, which occupies some nine or ten days. (2) Degeneration of the epithelial layer and attendant flow. (3) Renewal of the mucous membrane which is completed in nine or ten days, these blending together and succeeding one another continuously. Ovulation he does not consider the *direct* cause of menstruation, but thinks that an intermediate condition must be taken into account. The whole process is summed up as follows:

(1) Rupture of the Graafian follicle and escape of the ovum through the Fallopian tube into the uterus.

(2) Lodgment of the ovum in some fold of the mucous membrane and as a consequence of its pressure, swelling of the mucous membrane follows.

(3) If the ovum becomes fructified the menstrual decidua is transformed into the decidua of pregnancy.

(4) If not impregnated before its vitality is lost, it causes active congestion, degeneration of the mucous membrane, and the menstrual discharges.

(5) The congestion thus caused reacts upon the ovary and causes the rupture of another follicle. This certainly has the appearance of a rational explanation, and one *capable of demonstration*.

Another question which has attracted considerable attention, and one of decided interest to gynæcologists at least, is that contained in a paper presented by Dr. John Williams, at a recent meeting of the London Obstetrical Society. He claims to have demonstrated that "the ovarian and uterine arteries run along the sides of the uterus, and give off numerous branches which proceed horizontally inward and form circles around the organ; from these, vessels run toward the uterine cavity in a direction perpendicular to the surface. It results from this that each portion of the uterus has its blood supply secured to it at its own level, and is not dependant upon any segment above or below it. The arrangement of the veins is similar, and secures a free return of the blood."

As a consequence of this arrangement, he asserts that "a ligature may be tied completely round the uterus at any point above the vaginal junction without affecting the supply of blood either above or below; and that therefore flexions of the uterus can have no effect upon the blood supply, in the way of causing congestion." As this is in direct conflict with the mechanical theory of uterine congestion and displacements, its establishment as a fact must

effect a decided change, not only in the theory regarding these conditions, but in their treatment, by those who practice upon the mechanical basis.

Gonorrhœa as a cause of disease in women is too generally overlooked or ignored. That many women suffer from this cause without being aware of any possible exposure to it is equally true. That the gonorrhœal poison remains and may be transmitted long after the primary or acute symptoms have disappeared is a well established fact. In a paper read before the "Society of Naturalists and Physicians," Sanger of Leipsic, claims that gonorrhœa furnishes a larger per cent. of chronic affections of the pelvic organs than puerperal fever or syphilis, and that of all forms of tubal disease, the gonorrhœal are by far the most frequent. He thinks it probable that the infectiousness of latent gonorrhœa may be due to the presence of a spiral form of gonococcus and he considers it more dangerous and more persistent than is generally realized. He advises for women affected, a one per cent. solution of merc. cor. sub. as an injection both vaginal and uterine, and if the fallopian tubes are affected they should be extirpated. Not only is disease traceable to this cause, but a surprisingly large percentage of *sterile* women are undoubtedly the victims of this poison which destroys the vitality of the spermatozoa, whether existing in the male or female. Statistics show that 90 per cent. of all sterile women are married to men who have had gonorrhœa either before or after marriage, and while this does not prove that this is the cause of the sterility in all these cases the connection is significant, and it should be borne in mind that a very considerable number of these sterile women are so only because their *husbands* are sterile, and this latter fact is more frequently a result of gonorrhœa than any other cause, as one in every six who have had this disease are found by careful examination to be incapable of producing healthy spermatozoa. This dis-

ease then which many physicians treat so lightly, as of little consequence, should receive more serious attention and its victims warned of the evil consequences which are likely to follow it, and if a solution of merc. cor. will destroy the poison, or the germ if it be a germ, many men ought to be soaked in it for a considerable time before being allowed to marry.

ABSTRACTS.

IRRITABLE BLADDER.

Alexander W. Stein, M. D., of the Charity Hospital, New York, contributes the following knowledge of neuro-spasmodic conditions of the bladder, in a paper published in *The Medical Record* of May 16th, 1885.

"The vesical neck is the most sensitive part of the bladder. The fundus is infinitely more tolerant of pathological encroachments and stimuli than is the vesical neck." "Note the quantity of residual urine, often acrid and offensive, that unconsciously accumulates in the bas fond in certain forms of centric hypertrophy of the prostate."

"A calculus in contact with the vesical orifice provokes painful and energetic contractions; but when, by change of position, the stone is thrown into the body of the viscus, irritability is at once diminished and the frequency of micturition lessened. Appreciating, then, the fact that the neck of the bladder is the most sensitive part of the viscus, and that it is from this point that the afferent impulses originate which set into operation the coördinate movements necessary to bring about the physiological act of micturition, it is obvious that anything that will stimulate or irritate this portion of the organ, either directly or indirectly, will augment this sensibility to an unnatural degree, and produce the frequent and perhaps painful micturition which characterizes our complaint—*irritable bladder*. Again,

bearing in mind the intimate nervous connections which exist between the bladder and the neighboring pelvic organs, we cannot be surprised that any disease or disturbance in the latter arouses sympathetic action in the former, so that vesical irritability is excited not only by contiguous irritation, but as often by reflex irritation. Frequent and painful micturition is always a more or less prominent symptom when the bladder has itself undergone structural change; thus a contracted bladder or a concentric hypertrophy of its muscular coat, resulting from overwork in overcoming some existing obstruction to the outflow of urine (stricture, hypertrophied prostate), diminishes at times to a remarkable degree the capacity of the organ, and as the quantity of urine poured into it is not diminished, micturition becomes so frequent as to verily constitute an incontinence. But at present I do not wish to lead you so much to the consideration of "irritability" as it is symptomatic of pathological conditions of the bladder itself, as to those forms of the complaint in which it presents simply as a functional disturbance. As such, its causes may be classified into mechanical, reflex, local and constitutional.

As mechanical causes we have the various uterine displacements, pelvic, and abdominal tumors, etc. These conditions by pressing upon, distorting and even dislocating the bladder, tend not only to diminish its capacity, but worry and irritate it to increased functional activity, so that after a time a very small quantity of urine creates an irresistible desire to urinate, the patient holding water with the greatest difficulty. The habit acquired of emptying the bladder at short intervals, produces in time a diminution in the capacity of the bladder which may itself become a factor in the complaint.

As reflex causes we have the presence of ascarides, hæmorrhoids, ulceration of rectum, fissure of anus, abscess in ischio-rectal fossa, or between prostate and rectum, irritation or congestion of prostatic sinus or vesiculæ seminales,

excessive sexual intercourse or ungratified sexual desire, masturbation, phimosis, congenital insufficiency of meatus, stricture, urethral curuncle, vaginismus, pyelitis, calculus in pelvis of ureter or kidney, and the passage of gravel or blood clots along the ureter, among the numerous factors which have been known to provoke frequent and painful micturition.

It is common with women much employed on the sewing-machine, and exposure to cold almost invariably aggravates the trouble.

[TO BE CONTINUED.]

CÆSARIAN SECTION BY AN OX.

The following case is probably unique in medical literature. My memory is refreshed from notes taken by Dr. Means, who saw the case with me in consultation:

Mrs. Piskulla, aged 34, the mother of seven children and near full term in her eighth pregnancy, on November 15th, was gored by an infuriated ox. The horn of the beast entered at the anterior superior spinous process of the ilium, and made a rent extending to the umbilicus, and involving both the abdominal parietes and the walls of the uterus. The child was extruded through the wound in half an hour after the occurrence of the accident. When I arrived on the scene, I found the child fully delivered, but remaining attached to the cord, which I ligatured and severed. There being no dilation of either the os uteri or the vagina, I delivered the placenta through the rent and applied a bandage. The patient was almost lifeless from hæmorrhage and shock, and I placed her on morphine and whisky. On the following day she was still alive, and Dr. Means was called in consultation at 9:30 A. M. The small intestines escaped from the wound on the removal of the bandage, and were returned with much difficulty. The wound was now closed with interrupted sutures, a carbolized compress

was applied, and the morphine and whisky continued internally. At 5:00 P. M. of the same day I found the pulse 130 and respiration 25 per minute. The abdomen was greatly distended, and the vital powers were fast becoming exhausted. On the following morning I found on my visit that the woman had expired at 10:00 o'clock of the previous night.

Shakespeare speaks of Macbeth as having been torn from his mother's womb by a wild boar, but probably the statement must be charged to poetic license. I believe the case I have above reported to be the only authentic case of Cæsarian section performed by a beast, on record. It may be interesting to know that the child suffered little or nothing from the violent and unusual method of its delivery, and is alive to-day, a vigorous and thriving boy.—*Medical Age*.

SHORT STOPS.

PROF. ESMARCH OF KIEL, in reply to a question "how soon may an obstetrician resume practice after exposure to sepsis?" says: "If you have thoroughly disinfected yourself you can immediately enter upon obstetric practice. Time alone does not destroy septic dirt."

WHAT SHOULD BE AVOIDED IN TREATING INERTIA OF THE UTERUS? "The use of all oxytocics, *e. g.* drugs credited with the power of directly affecting the uterine muscle, and of causing or strengthening contractions, such as *Ergot*, *Cinnamon*, *Borax*, *Cimicifuga*, *Caulophyllum*, and many others. Of these the one most used is *Ergot*.

ETHER AND GALVANISM should never be applied at the same time. Dr. Hugh's reports an interesting case from his own practice when he was treating a patient for cerebro-spinal trouble, and had received a descending fronto-cervi-

cal constant current and a liberal douche of sulphuric ether to the top of the head. The patient was immediately thereafter conducted to the static insulated stool, and as the roller was applied up and down the spine, the ether on the head ignited.

To reduce Centigrade to Fahrenheit: Multiply by 9, divide by 5, and add 32. Thus, $80^{\circ}\text{C} \times 9 \div 5 + 32 = 176^{\circ}\text{F}$.

To reduce Fahrenheit to Centigrade: Subtract 32, multiply by 5, and divide by 9. Thus, $95^{\circ}\text{F} - 32 \times 5 \div 9 = 35^{\circ}\text{C}$.

Iodine 30 will often cure the endemic non-degenerated goitre and is often successful in the soft recent goitres of the scrofulous. In almost all other forms useless.

Vegetable Acids: These acids dissolve lead, tin, and iron. A tin can containing fruits is rapidly corroded after being opened; the can should at once be emptied after it is opened.

What should be avoided in treating inertia of the uterus? "The use of all oxytocics; *e. g.*, drugs credited with the power of directly affecting the uterine muscle, and of causing or strengthening contractions, such as *ergot*, *cinnamon*, *borax*, *cimicifuga*, *caul*, and many others. Of these the one most used is *ergot*.

Ether and Galvanism should never be applied at the same time. Dr. Hugh's reports an interesting case from his own practice when he was treating a patient for cerebro-spinal trouble, and had received a descending fronto-cervical constant current and a liberal douche of sulphuric ether to the top of the head. The patient was immediately thereafter conducted to the static insulated stool, and as the roller was applied up and down the spine, the ether on the head ignited.

EDITOR'S TABLE.

IN Dr. Hale's paper on Cardio-Uterine Remedies in the August No. two corrections should be made. On page 232 "*physical*" should read "*psychical*." On page 234 "*strychnia 1x.*" should be "*strychnia 2x.*"

WE have received the "prospectus" of the reorganized *North American Journal of Homœopathy*, which will be under the control and issued monthly by the Journal Publishing Club (limited) of New York. The club have appointed seven editors—what a team? Not tandem either—with Dr. George Dillow as editor-in-chief. If the *schema* is carried out as laid down in the prospectus, we shall indeed, have a Homœopathic Medical Journal well worth patronizing. If, however, the journal is to be published in the interest of any clique or set of New York physicians, sad will be the day that the club became incorporated, even if "limited," in its legal organization. We want, not more Medical Journals but better ones. The Gynæcological Journal extends a hearty welcome.

THE Western Society of Psychical Research.—Mankind has ever been imbued with an instinctive awe and love of supernatural appearances, exemplified in early ages by the deification of the powers of Nature; later by semi-superstitious reverence of such alleged mental phenomena as clairvoyance and mesmerism. Scientific education opposes the developement of these inherent qualities and assigns objective realities as a cause of subjective abstractions. While wavering thus between an acquired incredulity of events of a marvelous nature and a fanciful estimation of our relations to external nature, we are quite in a spirit to accord a hearty welcome to the formation of "The Western Society for Psychical Research"; an organization that will follow in its investigations, the work of collecting, recording and classifying facts relating to scientific research in the psychical domain. Aside from the effort to eliminate fraud and deceit in the relations of external impressions to the discriminating exactness of the senses, we view with pleasure the appearance of such a society in the west as a sign of the awakening attention of the public to matters pertaining to metaphysical phenomena, with a resultant interest in mental hygiene. From a purely therapeutic point of view we await a report of results from the committee on Psychopathy, a division of the society that will give attention to what is popularly known as "Mind-Cure, Faith-Cure, Metaphysical treatment, Magnetic healing, etc."

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Lime Juice & Pepsin.

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INTERSTITIAL PREGNANCY.*

JAMES C. WOOD, M. D., Ann Arbor, Mich.

Mrs. S., aged forty years; brunette; somewhat below the medium stature, and of rather a nervous temperament; but of the finest type of womanly character.

Family history.—Her father died of apoplexy, and mother of phthisis; one of her mother's sisters had an ovarian tumor. Commenced menstruating at fifteen. Her only child is ten years old, and twelve months after the birth of this child she had a miscarriage at the second month. She had plenty of milk for the babe, but of such a poor quality that the little one was threatened with inanition, and artificial nourishment had to be substituted. The suppression of the milk caused many bad symptoms, and left her feeble for some time, though the miscarriage was not followed by any serious sequelæ, menstruation recurring at regular in-

* Michigan State Society.

tervals, being normal in quantity and duration the following seven years. Three years ago she had an attack of pelvic peritonitis, caused by undue exposure of some sort, which came very near proving fatal and left an inflammatory deposit behind that has caused considerable pain and inconvenience. From that time on she has suffered from menorrhagia, which at times has been alarming. One year ago this became so bad that she was compelled to take to her bed and place herself under the daily attendance of Dr. James M. Long, whose patient she has been continuously all these years. The examination then made revealed, besides the inflammatory deposit, what was diagnosed as a fibroid growth of some sort, involving the posterior wall and fundus of the uterus. She was very much emaciated and anæmic from the loss of blood, but by the properly selected homœopathic remedy in conjunction with daily local treatment, she so far recovered as to be able to spend a season at the Northern Lakes, which still added to the improvement already begun at home, though never free from the menorrhagia.

About the middle of last January she was again taken with unusual symptoms, that for the second time necessitated almost daily attendance; dull, heavy bearing down pains in the pelvis extending to the back and down the thighs; great lassitude, with an obstinate hacking cough; weak and anæmic from the long continued drain upon the system; leucorrhœa, with at times clots of matter and blood in the discharges. No *nausea or vomiting*, with a fair but capricious appetite; headaches at times that were annoying and some constipation with a good deal of flatulency. On the 29th of March Dr. Long requested me to examine the case with him. Besides the facts given above I elicited the following: The usual menstrual flow made its appearance in January. In February she was unwell but one day, and in March, just four weeks from the day she was unwell in February, menstruation again appeared, and so far as

quantity and duration were concerned this was the most natural period she had had for three years. She had ceased flowing three days before I was called as counsel. I found her very much in the condition described above. The uterus could be plainly outlined through the lax abdominal walls, extending as high up as the umbilicus, the fundus tipping backward and to the left. In the region of the left Fallopian tube was a distinct tumor projecting from the uterus about as large as a small foetal head and with a broad base continuous with the uterine walls. It seemed hard and gave a perfectly resonant sound upon percussion. Upon making an examination per vagina the cervix was found hypertrophied, elongated and tipped forward; the os was dilated so as to almost admit the index finger, and from it there oozed a thick, sanious discharge. As far as the finger could discern through the posterior cul-de-sac the uterus was found indurated and uneven, and indeed this was the condition as far as the finger could explore through the rectum. The uterine cavity measured five inches. We could discover nothing in the interior of the womb by this exploration, which previous to this time Dr. Long had hesitated in doing, fearing the possibilities of a pregnancy, but which, with the gaping os, the offensive discharge and the utter absence of any resistance at the internal os, we now felt justified in doing. We explored the whole cavity as thoroughly as possible with the sound endeavoring by conjoined manipulation to raise the fundus so as to explore its posterior surface through the abdominal walls, but owing to the size of the uterus and the flexibility of the sound we could not. There were no obstinate adhesions as subsequent events proved. The history of the case seemed to point unmistakably to either a sub-peritoneal or interstitial fibroid. The gradually increasing hæmorrhage for the last three years, the peculiar pains extending down the thighs with increased weight and discomfort in the pelvis, together with dysuria, and at times tenesmus, the absence of any

cancerous cachexia or sudden inter-menstrual flooding, our inability to find polypi after exploring the cavity most thoroughly with the sound, and the want of the first symptom of pregnancy led us to unhesitatingly relegate the trouble to the domain of fibroma. The absence of any pediculation and the numerous indurated masses in the posterior uterine wall seemed to point to the interstitial variety. All was somewhat confused by the old inflammatory deposits, yet we could come to no other conclusion. Preparatory to anything that might be necessary in the future we ordered the hot douche to be used daily, after which a tampon saturated with hydrastis and glycerine was inserted giving internally Belladonna and Calcareo carb. in the medium potencies.

This treatment was continued until April 14th, with the effect of much reducing the swelling and congestion in the cervix and relieving the severity of the pelvic pains so distressing to the patient and rapidly exhausting her strength. We awaited patiently the return of the menstrual flow, but as there were no evidences of its return up to the thirty-eighth day after the last period, and as the patient was anxious for something more energetic, we decided to resort to the curette hoping thereby to not only control the menorrhagia but also bring about some change in the size of the organ, as is often done in areolar hyperplasia when complicated with chronic endometritis. There was no difficulty in dragging the womb as far down as was necessary, and the curette was most thoroughly applied *from the fundus to the cervix*, and upon all sides; an application of strong carbohc acid was made directly to the endometrium and the usual precautions taken to prevent any untoward symptoms. This procedure rewarded us with numerous fungoid growths and not the slightest inconvenience followed it, but on the contrary our patient was unusually bright for the next ten days. The "tumor," however, perceptibly increased from week to week and a correspondence was had with Prof. Baldwin, of the University, with a view

of considering the advisability of gastrotomy should the growth and hæmorrhage both increase.

On the morning of April 28th, she began to have peculiar bearing down pains, but no harder than had often preceded the advent of the menstrual period, and we supposed it to be only an effort of nature to overcome the disturbed equilibrium produced by our recent manipulations. The pains, however, increased in severity until the first of May—thirty days after the use of the sound and fifteen days after the curretting—when a somewhat distorted but *well preserved* foetus of three months was expelled. The flooding was alarming, but by the timely arrival of Dr. Long this was controlled, and the patient, under the influence of stimulants soon rallied from her syncope. The following four or five days she was very low from a condition simulating shock with much tenderness and pain in the region of the left fallopian tube and retention of urine, with evidences of circumscribed peritonitis. Under the influence of China, Veratrum and Bryonia, with vaginal injections of bichloride of mercury (1-2000) she is rapidly improving, though the tumor is yet there but much smaller. We are in hope that by availing ourselves of the mechanical action of Ergot and the properly selected tissue remedies, aided by the efforts of nature to restore the uterus to the natural size, to so far control the new formation as to make an operation unnecessary.

I can not but believe that this was a case of interstitial pregnancy and that the curretting so thinned the tissues between the placental attachment and the uterus as to cause the happy accident of a rupture into the uterine cavity instead of the abdominal. The authorities upon the subject are singularly brief as to the possibilities of such a termination.

Leavitt alone, in discussing tube-interstitial pregnancy says;—"When development takes place in the borders of the uterine cavity, the resulting tumor may crowd through

the Fallopian opening, and lodge in the uterus only to be finally expelled as in ordinary abortion," but cites no recorded cases where such was the termination. Guernsey briefly mentions the subject of extra-uterine foetation saying that the interstitial variety is the rarest of all forms of misplaced gestation. Partridge follows the same beaten track of most obstetricians discussing the accident in its several forms, but saying nothing about the possibility or probability of a rupture occurring into the uterus. Tyler Smith has a chapter discussing somewhat at length extra-uterine pregnancy, but augurs nothing but death for the mother unless the foetus becomes encysted or suppuration through the vaginal, intestinal or abdominal walls occurs.

Bedford simply winds up the subject of interstitial pregnancy by saying that it is as fatal as tubal, and in a record of sixty-four cases of the latter variety he shows that all but one terminated fatally. Jonathan Hutchinson Esq., in Brathwaite's Retrospect for 1874, gives a history of two cases that so closely simulated ovarian dropsy as to warrant paracentesis, one of which died from induced peritonitis, the other recovering, the contents of the cyst becoming disintegrated and passing out through the fistulous opening in the abdominal walls made by the needle.

In a monograph by Dr. Campbell, quoted by Hutchinson, there is a record of one hundred and two cases with the treatment and the result which is as follows: Twenty-one cases in which the foetus was allowed to remain quiescent, thirteen in which the mother died without any attempt, either natural or by art, having been made for the removal of the foetus; sixteen in which ulceration occurred and the remains were spontaneously extruded (three deaths); and lastly sixteen in which without waiting for suppuration to occur, the surgeon boldly cut into the abdomen and extricated the retained foetus. Of this number no fewer than seventy-two patients recovered; "but," continues Mr. Hutchinson, "probably the ratio of good results is far beyond the

real truth, since the cases which recover are precisely those the most likely to excite the interest and perhaps the astonishment of the surgeon and thus secure themselves record in print."

This is about the extent of the data from which I have had to draw. A more extended research into the literature of the subject would possibly yield authenticated cases where like terminations have occurred, but you will see that none of the authors quoted, except Leavitt, mention the possibility of the rupture occurring into the uterus. At least three-fourths of all cases have been on the left side.

My paper is already too long to discuss the pathology, diagnosis, etc., etc., which is very interesting. I think that the history of the case will bear me out in the diagnosis and I think, ladies and gentlemen, that none of you can censure us for exploring the womb under the circumstances. Indeed had not this been done there would have been no way of learning the location of the foetus and I cannot help but feel that the curette had much to do with the happy termination. I submit it for your consideration.

THE CARE OF THE WOMAN DURING GESTATION.*

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We believe this subject has not received the attention which it deserves. Of the books written upon the subject of Obstetrics to which we have had access, all, save one, pass the subject by, either saying nothing, or the general remark that the pregnant woman should take plenty of out-door exercise and make use of a healthful, nutritious diet. Why should not the non-pregnant woman do the same?

Richardson devotes a chapter to the "Hygiene of the

* Michigan State Society.

Pregnant Woman," which we think every obstetrician would feel well repaid for reading.

We believe that a pregnant woman can be put upon such a course of living as will enable her to avoid much of the sickness and discomfort which usually attends gestation and will almost guarantee a safe and speedy delivery.

During the past five years we have pursued a uniform mode of treatment in the care of the pregnant woman, and feel very well satisfied indeed with the results obtained.

The principal treatment has been hygienic, although, of course, there have been occasions calling for the administration of remedies.

It will not be necessary to discuss the importance of the patient having plenty of out-door exercise, or that tight fitting clothing should be done away with, or that balls, parties, etc., should be abandoned.

Above everything else we regard the regular habitual use of the *hot* sitz-bath and the fruit diet as productive of the most good.

When the sitz-bath tub cannot be had, a common wash-tub can be made to answer the purpose very well. Tip it up to an angle of about forty-five degrees and fill with water as *hot* as the patient can bear it without scalding, then let her sit down in the water and remain there at least thirty minutes, adding a fresh supply of hot water as it becomes necessary to keep up the temperature. Some are made quite faint at first, but they soon become accustomed to the heat and then have no more trouble. This bath should be taken once a week up to the eighth month, during the eighth month twice a week, during the ninth month every day. A few physicians have objected to this procedure, fearing an increased danger of abortion or post-partum hæmorrhage. We have not found this to be the case, and in two instances where there had always been severe post-partum hæmorrhage in previous labors, there was none after the use of the bath.

We believe the constant regular use of the hot sitz-bath during gestation prepares the os for easy and rapid dilatation, renders the muscles and perineum pliable and elastic, and reduces the liability of rupture to the minimum. It relieves the pains in the back to a great extent, as also the vesical pain and tenesmus so often a cause of complaint.

Whether the fruit diet renders the bones of the foetus soft and thus assists labor, as Prof. Richardson maintains, we are unable to state. Have noticed no marked difference in that respect; but have noticed in very many instances the absence of the "morning sickness," "heart-burn," and the gastric disturbances which so frequently accompany pregnancy. In a few instances chronic constipation has disappeared entirely. Some are found who cannot use the fruit diet. In such cases it has to be abandoned; but a large majority are more and more pleased as they become accustomed to its use.

The medicinal treatment is rather outside the scope of this paper, but will say in a general way that it is governed by the patient. The Pulsatilla patient is well known, and when that remedy is used is generally given a dose daily for two weeks before expected time; generally the 200. Sometimes have used Cimicifuga or Caulophyllum; generally the 30x.

By way of illustration will mention a few cases.

Case 1.—Mrs. W——, fourth pregnancy. The three previous labors had been remarkably severe; all necessitating the use of the forceps, and the third was so severe that her attending physician had (foolishly) remarked that she never could live through another. When she found herself booked for the fourth trip she became exceedingly despondent and nervous. Her husband became alarmed at her condition and came to me for assistance and it was then I first learned her previous history. Gel. *o* was administered and she was immediately put upon the fruit diet and ordered to take the hot sitz-bath every week and a safe and

easy labor confidently predicted. During the whole time of gestation she frequently remarked that she never had got along so well before, and although she lived but four blocks away and sent for me when she felt the first pain, a twelve pound boy was born before I could reach the house. I confess to having been very anxious about this case and am firmly convinced that that happy result was obtained by the fruit diet and sitz-bath.

Case 2.—Mrs. H——, aged 37, Belgian. And here let me remark that in my experience the Belgian women have the hardest and most tedious labors of any I have attended. This was also a fourth pregnancy. She was a strong muscular, hard working woman. Her previous confinements had never been less than thirty-six hours long. Her husband came to me saying, “he heard I had a way of making a woman have a baby easy” and wished me to attend his wife. Ordered the fruit diet and hot sitz-bath. The programme was followed to the letter. In due time was called and upon arrival at the house found that labor had been in progress about two hours; head well down on floor of pelvis and face presentation. In about an hour we were through and time of labor cut from thirty-six hours to three. If this was not the result of the diet and bath what was it?

Case 3.—Mrs. S——, aged 20, primipara. Family history was that labor was unusually severe. Her mother had had seven children and instrumental labors in nearly every case. The shortest labor had been thirty hours. Three sisters had each had equally severe labors. She was put upon the fruit diet and hot sitz-bath treatment. In due time she was delivered of a nine-pound boy and from the first pain to the completion of the third stage of labor was two hours forty-five minutes.

Any number of cases could be cited all with the like result of easy and rapid labors, but seems to me these are sufficient.

Now, is it not reasonable to believe that these uniformly

good results were brought about by the use of the fruit diet and hot sitz-bath? Am aware, it by no means follows that because one labor has been severe the next will be also, but when the history of the woman says, always severe labor, or in primiparæ we get so uniformly good results, how can we arrive at only this conclusion, viz.:

The persistent use of the fruit diet and hot sitz-bath during gestation very materially assists towards an easy and rapid labor.

NEOPLASMS OF THE OVARY.

A. McNEIL, M. D., San Francisco, Cal.

On reading the article with the above heading in the American Homœopathic Journal of Gynæcology and Obstetrics I was struck by the following passages: "Parental indulgences must be curtailed," and the procreative function is for the reproduction of the species and not for sexual gratification, and this indicates that the rights of the unborn created must be respected in the interests of all concerned." This presumes that married people can and should only indulge in sexual intercourse at long intervals, say three or four years. It follows that if they can do this, they can refrain entirely, unless they conclude to increase their family. What would result? Who would have children? As much additional labor is required by the advent and presence of a baby, who would have one unless they could afford a servant until its infancy was passed?

As much expense is involved, who would desire a child unless they were well satisfied with their pecuniary affairs? As a woman's social and other pleasures are interrupted thereby, who would thus voluntarily renounce them for a long time?

As pregnancy for a time destroys the symmetry of the female form, what woman would thus impair her good looks?

As pregnancy, child-birth and nursing produce sickness and pain, who would make a martyr of herself?

As children do not always reflect credit on their parents and prove a source of happiness when mature, who would cheerfully assume this responsibility?

And again let us investigate the truth of the assertion that sexual indulgence is the great cause of new growths in the ovaries.

John Epps, M. D., in his classic work on *ovarian diseases*, analyzes the vast number of his cases of ovarian tumors with reference to their causes. He found that nearly all the cases were in the following classes: Old maids; widows; women with husbands much older and presumably less amorous than themselves; and old women with young husbands. Cases were extremely rare in women married to men equally well "sexed" as themselves.

It is clearly established that married women as well as men enjoy better health and live longer than the unmarried. And people who have sexual intercourse once in several years could not in a sexual sense be considered married. I think, moreover, that I would be safe in saying that what he asks is impossible for healthy people, and that if any married man not impotent asserted that he thus lived, he could not swear long enough or loud enough for even Dr. Runnels to believe him.

The conclusion is inevitable that our Creator wisely left the continuance of the human race not to our discretion, but to our passions.

I can understand that when such papers were read before the American Institute, that as the genial editor of the *ADVANCE* approvingly quotes what a disgusted member wrote him, "I confess I was greatly disappointed in the meeting of the American Institute of Homœopathy. But very little transpired, calculated to aid a young man in prescribing for his patients. What is the object of these meetings? For what do members spend their time and money? To elect a President or Secretary? How long has this been so?"

Judging from the above paper, the ætiology and prophylaxis displayed were no better than the therapeutics. "How are the mighty fallen." There was a time when the chair of the American Institute of Homœopathy was filled by Hering, Dunham and others, now not exactly . . . but—?

ABSTRACTS.

IRRITABLE BLADDER.

(Concluded.)

The bladder naturally resents the presence of urine that has undergone any change in its physical or chemical conditions. Urine that is over-acid or over-alkaline, too dense or the reverse, is not well borne by the bladder. Hence all constitutional disturbances that reflect on the composition of the urine are causes of irritable bladder; mal-assimilation, primary or secondary; a scrofulous, rheumatic, or gouty condition of the system; the inhibition of certain drugs, such as cantharides, diuretics in large or long continuous doses; alcohol, asparagus, strawberries, etc., are factors in the causation, which require recognition and proper interpretation. Especially is the presence of pus or blood intolerable to the bladder, and thus it happens that frequent and painful micturition are often the first symptoms which point to the existence of serious disease in the urinary tract above. While I wish to avoid unnecessary repetition, I would again impress upon you the fact, that not only is frequent and painful micturition a symptom common to many ailments in which the bladder is not sympathetically involved, but that with these symptoms there may be pus in the urine, even in considerable quantity, which may make the bladder symptoms so prominent as to completely mask the real disease and mislead you to the belief that you have a veritable inflammation or disease of the bladder, when this organ is almost or wholly unaffected.

Do not harass the already overtaxed bladder with treatment for a disease of which it is innocent.

On the other hand, you must remember that, as increased vascularization is the natural sequence of prolonged irritation, it frequently happens that the irritated bladder is at the same time congested or inflamed, furnishing pus; and now, again, you must be on your guard that you do not accuse the bladder of the original cause, which may be apparent elsewhere. In these cases it is always important to ascertain whether the pus contained in the urine is derived from the bladder or from the urinary tract above. This is determined by thoroughly washing out the bladder, and then, the patient standing, allowing the urine to trickle through a soft catheter as it comes from the ureters. If the urine thus accumulated contains pus, the conclusion is that the source of the trouble is beyond the vesical cavity.

Finally, if after deliberate search you cannot reconcile cause and effect, you are forced to the conclusion that your trouble is of neurotic origin. It is often concomitant with psychic disturbances, nervous depression, close mental application, anxiety, fear, excitement, fright, etc. In these conditions the frequency of micturition is often due as much to an increase in the quantity as to the change in the quality of the urine; notably so in the hysterical attacks of women, in whom the renal secretion is not only pale and limpid, but very abundant.

Therefore we have to make distinction between those conditions in which the frequent micturition is the result of rapid accumulation from excessive production—the quantity of urine passed each time being quite considerable—and true irritability, in which the quantity passed is small, often but a few drops. Again, in the latter condition, pain, if it does not exist at the outset, very soon becomes a marked feature. It may be slight, it may be severe, according to the causation and duration of the complaint; it is often of a burning or scalding character; it

may be limited to the vesical neck, or, having its origin here, may radiate in various directions, especially toward the glans penis and rectum. Sometimes the pain is felt during micturition, but usually is most pronounced with the final expulsive effort of the bladder. Irritable bladder and incontinence of urine have so much in common as regards their etiology, that the one is frequently associated with the other. These patients often complain that they wet themselves. When the complaint is of purely neurotic origin, it is especially characterized by the inconsistency and variableness of its symptoms—present one day, gone the next; severe at one time, slight the next.

The paroxysmal form is analogous to neuralgia of the vesical neck, and the terms irritable bladder and neuralgia are often used synonymously. Again, there may be spasm of the bladder. This, when a distinct complaint, differs also from simple irritability in the decidedly paroxysmal nature of the attacks, during the intervals of which the person is at perfect ease. The paroxysm consists of a constant desire to void urine, with violent tenesmus or bearing-down pains. The urine is expelled, sometimes involuntarily, always in small quantity and in an intermittent and spasmodic manner. Often, however, the patient will stand and strain to pass water ineffectually, for now the spasmodic condition of the external sphincter is in the ascendancy, and the antagonism of the latter to the “detrusor” is such that, while allowing the escape of jets of urine during momentary periods of relaxation, the bladder is not permitted to empty itself completely, and more or less retention exists until the cessation of the attack.

The indications for treatment range themselves with the causes of the complaint; hence it is important to bear in mind that the bladder symptoms are often but the signals of distress pointing to some remote trouble, which if sought for, recognized and removed, will cause the bladder symptoms to disappear without any special treatment directed to

it. The first thing to be done is to investigate the condition of the pelvic organs and examine as to the existence of any external or reflex source of irritation, which, if present, will be dealt with in a manner called for by each. At the same time the condition of the urine is to receive immediate attention. If found at fault, the next thing is to ascertain the cause or causes which produce the disturbing quality in its composition, whether it is due to some constitutional taint, to a gouty or rheumatic diathesis, to improper diet, imperfect digestion, mal-assimilation, sedentary occupation, or some other peculiar habit of life.

Attention must be directed to the diet. Alcohol in any shape is obviously interdicted. A rich animal diet tends to increase the production of urea and uric acid and to intensify the acidity of the urine, asparagus, spices of all kinds, and certain fruits are to be avoided. In short, the food and drink must be unstimulating to kidneys and bladder, very digestible, and adapted in quality and quantity to the requirements of the system, always remembering that while high living and excesses are to be carefully avoided by the plethoric and robust, a more generous regimen and tonic treatment will be required by the anæmic and impoverished of blood. Milk in liberal quantities, even for a time as an exclusive diet, has proved of excellent service in these cases. Digestion, if impaired, must be assisted, the bowels kept free, not by active cathartics, but by the mildest means that will serve to relieve the hæmorrhoidal vessels and nerves from pressure and irritation. General hygienic rules are to be laid down, with possibly change of air and scene.

Having done what we can to correct any condition of system which may give rise to irritating urine, we turn next to the immediate alleviation of pain, which is especially demanded at night.

[This can be best accomplished by prescribing for the *patient*, not for the "irritable bladder."—ED.]

THE DANGERS OF COCAINE IN GYNECOLOGICAL PRACTICE.

(A PARTIAL PROVING.)

In the enthusiasm over this wonderful new remedy we have heard of its successes only; it is well that we should know of its ill effects also that we may guard against them, as many constitutions, especially those of delicate, nervous women, upon whom we are, in gynæcological practice at least, most liable to use it, are very readily affected, even by the local use of small quantities. But different patients seem to be very differently affected by the drug. The ill effects I have recorded have been the result of the application of from ten to twenty drops of a four per cent. solution to the uterus or vagina, say about one-third to two-thirds of a grain.

Mrs. K., an extremely delicate, nervous person, suffering from great depression in consequence of a laceration of the cervix during her first labor, received all the benefits which could be expected from a local application to the intensely irritable cervix, but within two minutes after an application felt a certain pain and smarting at the point of the application. A few minutes later a nausea appeared, which continued for perhaps two hours, when it culminated in retching, which was more or less severe according to the quantity of cocaine used, and not till after the lapse of three or four hours did these symptoms disappear.

Mrs. W., an elderly lady of weak and nervous constitution, suffering from prolapse and excessive irritability of vulva and vagina, was treated with the application of from ten to thirty drops of a four per cent. solution to these sensitive parts, preparatory to reposition and use of astringent tampons. The local effect was all that could be desired, but was accompanied by a most annoying oppression in the region of the chest, some dizziness and a nausea which continued for many hours.

Mrs. G., a stout, hearty-looking young lady, suffering

from endometritis, received an application of cocaine to the very sensitive endometrium, preparatory to the use of Carbolic Acid. Upon her the constitutional effect was most delightful; for several hours after the application she felt well and happy, inclined to sing and be merry.

The internal administration of the drug, to which I have resorted in many instances to relieve the vomiting from chloroform after operations, is not without its dangers. In some instances a small dose does not have a distinct toxic effect; yet the poisonous effects seem to vary greatly.

Mrs. C., aged 28, in fair health, had undergone an operation for laceration of the cervix at 11 o'clock A. M. She was somewhat nauseated after recovering from the anæsthetic, and was given from half to two-thirds of a grain of cocaine, in a table-spoonful of water, to be taken in tea-spoonful doses, containing perhaps a sixth of a grain of cocaine, if the stomach became annoying. At five o'clock she took one tea-spoonful of the solution, perhaps a sixth of a grain; an hour later, at six o'clock, she took a second tea-spoonful, after which she felt a slight tingling in her hands, extending somewhat above the wrists, mostly in the fingers. When lying perfectly quiet she was free from nausea, but would vomit the moment she turned in bed, and she claimed that the matter she threw up was unusually bitter. After each spell of vomiting she was greatly relieved and easy even of these symptoms of discomfort and oppression about the chest, and easier of the tingling in the hands. At half-past seven she took the third tea-spoonful; she now became excessively restless. At 7:45 she was throwing her legs and arms about, moving her hands and feet; experienced great difficulty in breathing; felt as if a band was drawn tight around her chest; was obliged to keep her hands above her head in order to relieve the respirations; felt as if she was fading away. The greatest oppression was experienced on the right side, so that she would turn and lie on the left side. At eight o'clock I saw the patient;

she was faint, as if fading away; breathing with difficulty, arms above the head; the tingling, which had at first been in the hands and forearm, was now in the feet and legs, most in the ends of the fingers; at a quarter past eight, extending up the lower leg, less in the hands and worse in the feet; vomited freely, and in a few moments felt perfectly relieved; the sensations returned very soon; at a quarter past eight tingling yielded to a numbness, which began in the hands and extended to the feet; then she became perfectly still, as if breathing her last; perfectly numb; became stiff; the thumbs adducted; the pulse, feeble and rapid at first, is now intermittent and irregular; fingers stiff; numbness most intense in the knuckles. Dr. Atkinson, the family attendant, who was present, suggested that a hypodermic injection of morphine be given to relax the system. One-sixth of a grain was accordingly injected with a most happy effect. The tense muscles relaxed; the breathing became easier, and the patient was soon comfortable. The toxic effects of the cocaine had been entirely overcome. I would call especial attention to the fact that this constriction seemed in the chest, especially on the right side, while the heart was free, no discomfort whatsoever being felt there.

Mrs. F., aged 35, the mother of two children, was suffering from nausea of pregnancy, which had existed for three or four weeks when I was first consulted.

I made an application of a four per cent. solution of cocaine to the slightly eroded cervix with a most happy effect. Upon the following day I called again, taking a vial containing two drachms of a four per cent. solution—five grains of cocaine—and whilst conversing with the patient, I gave her some five or six drops, perhaps one-tenth of a grain, in a few teaspoonfuls of water in a sherry glass; I then made an application to the cervix and cervical canal, using perhaps a drachm of the fluid, some two and a half grains locally, and after the application, while giving her

instructions, again administered five drops in a sherry glass, with a little water, thus having used perhaps one-fifth of a grain internally and about two and a half locally. The patient experienced great relief, but being unexpectedly summoned to one of the Northern States that night, I was unable to see her upon the following day, and so informed her. Having been greatly relieved by the treatment, and experiencing return of the nausea, she determined to take the cocaine as I had given it to her. Presuming that I had given her all the cocaine internally, and seeing that I had used the greater part of the vial, at least two-thirds, she concluded to take the remaining one-third, about two grains, upon her own responsibility; thinking that as I had given her, as she presumed, so much more, the smaller quantity, one and a half to two grains, would do her no harm, she accordingly took the remaining forty drops of the four per cent. solution, just as it was, at one dose. A weakness soon overcame her, with an oppression about the heart, symptoms which she had often before experienced when suffering from her dyspepsia; although, when suffering from dyspepsia, with these feelings she had been excited, nervous, walking about, and now she was quiet, as if fading away. Immediately after taking the dose she felt a complete numbness along the left half of the tongue and throat, extending downwards to the stomach, distinctly describing the course of the esophagus; to test the feeling, she bit her tongue, and found it perfectly dead or numb. Within fifteen or twenty minutes the entire body became cold and numb; her hands were wrapped in hot flannels; hot irons put to the feet; her breathing was free, but her heart felt as if constricted by an iron band. Frightened by this feeling of weakness, of fading away as if she were dying, she got up and walked about to test her strength, but the feebleness of her heart, which beat with intense rapidity and loudness, would force her to sit down again. She felt neither the tingling in hands and feet, nor the numbness and oppres-

sion of the chest, which had been experienced in the previous case, Mrs. C. With rubbing, and hot applications to her hands and feet, her body by-and-by became warm, but the oppression and constriction of the heart continued throughout the day, even until bed-time. Being confident that the dose of cocaine which she had taken was much smaller than the one I had given her, she had no thoughts of a poisonous effect, but attributed this feeling to an attack of dyspepsia. She tells me that her condition was such that had she thought she had taken an overdose of cocaine, she would not have survived it. She lay for the greater part of the time, quietly, feebly and perfectly relaxed, in an easy chair, but when the feeling of fading away threatened to completely overcome her she would walk about, then this rapid hammering of the enfeebled heart, which beat at such a fearful rate, would again cause her to sit down. Toward four o'clock the severity of the symptoms lessened, although they did not pass away until bed-time. During all this the head was not affected at all, and the lungs were also free.

I record these cases to impress the necessity of caution in the use of this remedy, and to show how much we yet have to learn with regard to its effects. Some constitutions seem to suffer toxic effects from small quantities locally applied. Again, we hear of a half a grain being taken internally by physicians experimenting with the remedy, or the same quantity injected hypodermically without ill effect.

That may be the case in strong, healthy males, but nervous women are far more easily influenced. The range being so wide a one, it will be far safer to repeatedly give small doses at intervals of two hours, at least until we become familiar with the susceptibility of the individual.—*Weekly Medical Review*.

RAPID DILATATION OF THE UTERINE CANAL.

D. Tod. Gillman, M. D., summarises his experience in the practice of rapid dilatation of the uterine canal in a paper in the *Medical Record* of May 9, 1885, as follows:

"Having now for some years used rapid dilatation in lieu of tents, I am satisfied that it is much safer and incomparably more efficient. It is more efficient because, as I believe, in rapid dilatation carried to the extent herein recommended, we have a breaking up of the sub-mucous tissues, which forever destroys the integrity of malformed parts and renders impossible that spastic condition so generally found associated therewith, by reason of fretted and overtaxed nerves. Where this is not accomplished no permanent good is likely to ensue. As illustrative of this fact, instance the patulousness of the cervical canal, immediately following the menstrual effort, even in cases characterized by the most pronounced dysmenorrhoea. Here is dilatation apparently as effective as need be, and yet the trouble recurs at each succeeding menstruation with invariable certitude. Now the dilatation effected by tents is similar to that accompanying the menstrual effort, and, barring the chance of inciting to nutritive changes, no more efficient. The tents, moreover, by their long sojourn fret and irritate the tissues beyond all endurance, and by preventing drainage conduce to septic and inflammatory troubles. As in rapid dilatation we seek to lacerate the unnatural bridges and bands of muscular and connective tissue, which if done without producing a surface breach usually heal kindly and with facility, it follows that a comparatively narrow blade is more efficient than a broader one, and hence the expanding dilator is preferable to the sound.

"The means of rapid dilatation resolve themselves into two classes, *i. e.*, sounds and diverging blades. The sounds are made of hard rubber or steel, and are slightly conical

or olive-shape, and of graduated sizes. These dilate by being forced into the uterine canal one after another consecutively, according to size. There is something fascinating in the use of sounds; as the ease of manipulation, the equable expansion at all points, and the beautiful circular enlargement of the canal comport with one's ideas of an ideal dilatation.

"In using the sounds the patient may be placed either on the back or in the Sims position. If on the back a Nott's speculum will be found most advantageous. The cervix now being fixed by a strong tenaculum, one of the smaller dilators is introduced. In performing this manoeuvre care should be taken to direct its course in conformity to the trend of the canal as previously ascertained by the uterine probe. If there be much difficulty in passing the internal os, the probe may again be introduced, and will then act as a guide to the dilator. In such cases it is always better to place the patient in the Sims position, and use the Sims speculum. To one not accustomed to the use of the Sims method for the purpose in question, the facility of introduction secured by it will be something surprising. The operator must bear in mind that the cervix is very extensible, and under the opposing forces exerted by the tenaculum and the dilator often becomes much elongated. This may prove misleading, inasmuch as he may think that he has passed the internal os, when in reality it has been pushed before the point of the dilator. He will know when he has passed it by the freedom with which the instrument can be advanced into the uterine cavity, the latitude of motion which can be communicated to it, and by its remaining *in situ* when left to itself. If, on the other hand, it has not passed, it will rebound when the pressure is removed. One after another of the graduated dilators is introduced successively, allowing a few minutes' sojourn for each until a degree of dilatation commensurate with the needs of the case has been attained. Unfortunately, as ordinarily made,

these dilators do not run above No. 18 American scale for sounds, and are inadequate for permanent good.

"A dilatation, in order to be effective and permanent in its good effects, should give a circle of at least one-half to three-fourths of an inch in diameter. Such a dilatation once accomplished will seldom need repetition, and will in most cases permanently relieve the angularity or stenosis upon which may depend the sterility or dysmenorrhœa. For full dilatation the patient should always be thoroughly anæsthetized, and it is a good plan to follow the example of Professor Goodell, by exhibiting a rectal suppository containing a grain of the aq. ext. of opium before beginning. I am becoming more and more convinced that the principle of the use of sounds is faulty, in that the cervix is elongated by counter-forces at the time of dilatation, whereas it should be shortened in proportion to the degree of lateral expansion. Then, again, on account of the circular outline of the sound, submucous malformations are less easily broken than with the expanding blades, and lastly, the repeated introduction and withdrawal of the successive sizes cannot but prove more or less detrimental. Several mischances, in the form of pelvic peritonitis, long since admonished me to greater circumspection in their use. In the use of expanding dilators I have finally adopted the Ellinger. This has the advantage of a fulcrum support not far removed from the beak, a great degree of expansion, and a parallel action of the blades. This latter I deem of much importance in all cases of extensive dilatation, as there is much less liability to injure the uterine structures than when the blades diverge like those of a pair of scissors. There is, however, something of a tendency of the blades to slip, and unless care be exercised the cervix may be torn by an accident of this kind. The instrument being introduced with the blades closed, in the same manner and with the same precautions described above, the blades are separated by a gradually increasing pressure on the handles.

I do not intermit the pressure as advised by some, but push the dilatation steadily and as rapidly as a feeling of safety for the general integrity of the cervix will permit. As a true divulsion is the object in view, there should be no mincing, but a steady, inexorable advance, so that the tissues may be quickly and effectually overawed and subjugated. As a rule the dilatation should be carried to the full capacity of the instrument, which making allowance for the spring of the blades, will be about an inch. Exceptionally one will have to deal with an undeveloped cervix, or one so brittle that he will not feel safe in proceeding so far. In these cases he will content himself with less radical measures, but will usually find that a repetition becomes necessary if he would benefit his patient. After the lapse of some weeks he will not infrequently be gratified to find evidences of development in the hitherto immature cervix, and may now be able to perfect his work. Occasionally several seances will be necessary before full dilatation is accomplished, but these should always be at intervals of several weeks, in order to give time for the completion of the nutritive changes inaugurated thereby.

"Since becoming familiar with the use of the Ellinger instrument, I seldom use the sounds except in a supplementary way. When there is difficulty in effecting introduction, one of the smaller sounds will frequently open the way more advantageously than anything else, and I sometimes follow the Ellinger with one of the larger sounds, which by its uniform pressure at all points conduces to those nutritive changes by which absorption and reposition are effected and the uterine canal finally straightened and enlarged. It has become the fashion among operators to reverse the instrument after dull dilatation, so as to make its curve antagonize that of the uterine canal, and thus to bend the womb in the opposite direction. This I seldom resort to, feeling that the risk of injury to the uterine structures by the beak of the instrument more than counter-

balances the advantages sought. Dilatation having been accomplished, the dilator is allowed to remain in place for some moments, when, being withdrawn, a solution of bichloride of mercury, one to one thousand, is applied to the canal. I sometimes use iodoform in its stead, which I throw into the cervical canal by means of an insufflator. I never use the uterine plug, from a distrust of its safety and for the reason that a perfect dilatation will in time work its own changes. I am aware that some of our best gynæcologists are partial to the use of plugs of glass or hard rubber, grooved or perforated for facilitating drainage, yet as with more thorough dilatation the risk is less, and results equally good, I see no reason to abandon my present practice. The oculist of to-day seldom resorts to the stile for the correction of stenosis of the nasal duct, and we are all aware of how thoroughly certain spastic conditions of the urethra and anus are removed by one thorough dilatation. Is not the same principle applicable to the uterine canal? I may add that for some time past I have dispensed with the vaginal plug in the treatment of vaginismus, and rely entirely on forcible dilatation under ether, followed by a long period of absolute non-interference. My success has been unexceptional. It would be easy to multiply instances illustrative of the principle here involved, but they are sufficient to shield it from the implication of novelty.

DIGEST TO DISPLACEMENTS OF THE WOMB.

LOCAL SYMPTOMS.	Before menses, nosebleed :
Prolapsus uteri , when straining	<i>Hydr.</i>
at stool or urinating; rises again	—, pain in mammæ: <i>Con.</i>
when walking about; <i>Bell.</i>	During menses , pressing down
—, after cessation of menses :	from loins: <i>Lach.</i>
<i>Agar. musc.</i>	—, agonizing pain, with tossing
—, with ulceration of os and	about: <i>Acon.</i>
cervix: <i>Arg. nitr.</i>	—, colic: <i>Caul.</i>
— with indurated os: <i>Hydr.</i>	—, red tongue, with dark spots
—, with stinging in os: <i>Calc. c.</i>	and burning: <i>Merc.</i>

- Retroversion:** *Caul.*, *Ferr. jod.* **Menses**, scanty: *Con.*, *Lach.*, *Lil. tig.*
- Bearing, pressing down:** *Agar.*,
Calc. c., *Cham.*, *Lach.*, *Plat.*, *Sul.* —, —, black and of putrid odor: *Ign.*
- Pressing down**, as if everything would come out: *Bell.*, *Nitr. ac.*,
Sep. —, thick, black and acrid: *Sul.*
— flow more abundantly in the night: *Amm. mur.*
- , has to cross her limbs: *Sep.* **Menses** flow as long as she is moving about: *Lil. tig.*
- , must press with hand against vulva: *Lil. tig.* — too soon, with pain in small of back and in belly: *Amm. mur.*
- , feels as though she had to hold it up: *Merc. sol.* — — and too profuse: *Calc. c.*
- through the vagina on stooping: *Lyc.* —, profuse: *Plat.*
- from loins down: *Lach.* —, suppressed after fright: *Lyc.*
- from small of back down towards front: *Arg.* —, —; sterility: *Con.*
- from side of abdomen early in morning; has to sit down: *Natr. mur.* **Flow of blood** between the period: *Bell.*
- Pressing down**, with burning in uterine region: *Nux. vom.* **Frequent discharge** of coagulated blood: *Cham.*
- , with sensitiveness of parts: *Plat.* **Profuse discharge** of hot water from womb: *Hydr.*
- and drawing in legs during menses: *Con.* **Leucorrhœa**, jelly-like: *Sep.*
- and tearing pains in the veins of the legs: *Cham.* —, milk-like: *Calc. c.*
- and pulling in both thighs: *Merc.* —, mucous, profuse: *Caul.*
- , extending through groins as far as the small of back: *Plat.* —, like white of egg, with great sexual desire, although coition is painful: *Hydr.*
- Sense of weight** in pelvis after lifting a heavy load: *Aur.* —, smarting, burning, excoriating: *Con.*, *Hydr.*, *Ign.*, *Sul.*
- Labor-like**, colicky pains: *Cham.* —, —, —, —, with aversion to coition: *Hydr.*
- pains during menses: *Lach.* —, with pain in small of back: *Kali. c.*
- — and leucorrhœa: *Ign.* **GENERAL SYMPTOMS.**
- Kali. c.* **Desire** to be alone, brooding to herself, full of grief: *Ign.*
- Congestion** and irritability of uterus: *Caul.* — to self-destruction: *Aur.*
- Inflammation:** *Acon.* **Always in a hurry**, without accomplishing anything: *Lil. tigr.*
- Pain** in left ovary and loins: *Arg.* **Disinclination** to move: *Sep.*
- in groin; has to walk crooked: *Amm. mur.* **Easily Moved** to tears: *Puls.*

Pressure upon rectum, that she
can neither stand nor walk:
Ferr. jod.

Vagina dry: *Bell., Lyc.*

—, and painful embrace: *Natr.
mur.*

—, aching: *Calc. c.*

—, burning and itching and
pimples around pudendum: *Sul.*

—, bleeding from, after painful
coition: *Arg. nitr.*

Headache, on waking every
morning: *Notr. mur.*

—, and backache: *Hydr.*

Congestion: *Bell.*

Heat, on top of head, with cold
feet: *Sul.*

Dizziness, and roaring in ears:
Bell.

—, on walking up stairs: *Calc. c.*

—, when lying down, looking
around, or going down stairs:
Con.

Paleness, of face: *Puls.*

Bloated, especially between eye-
brows and upper lids: *Kali c.*

Yellow Saddle, across bridge
of nose: *Sep.*

Red tongue, with dark spots
and burning during menses:
Merc.

Taste, salty: *Merc.*

—, bad in morning, dryness
without thirst: *Puls.*

Desire, for hard-boiled eggs:
Calc. c.

After Eating, regurgitation of
food by the mouthful without
nausea: *Hydr.*

Despondency: *Sep.*

Dejected, longing for death: *Aur.*

Fear of Death: *Acon.*

Irritability and nervousness:
Hydr.

Can hardly stop talking about
old vexatious things: *Cham.*

Vehement, least contradiction
excites her wrath: *Aur.*

Quarrelsome and angry: *Cham.*

Haughty: *Plat.*

Inexpressible feeling of some
internal illness: *Merc.*

Inclination to sigh, cannot get
the breath deep enough: *Calc. c.*

Bearing down pains, take her
breath away: *Sep.*

Induration, in mammae and
other glands: *Con.*

Palpitation of heart, with
trembling: *Plat.*

—, with numbness of left arm:
Lach.

Back, aches as if it would break:
Bell.

Back, sore and weak, especially
after washing: *Pod.*

Small of back, pain in, as though
it were pressed in from both
sides: *Kali c.*

—, drawing downwards: *Bell.*

—, pressing worse when turn-
ing in bed: *Nux vom.*

Small of back, pain in, through
hips down the thighs: *Nitr. ac.*

—, pain in, relieved by lying
on a hard couch: *Rhus tox.*

Thighs, drawing in: *Nux vom.*

Limbs, jerking of, or of whole
body, sleeping or waking: *Lyc.*

Feet, fidgety of: *Zinc.*

- Gone feeling**, in pit of stomach: —, damp and cold: *Calc. c.*
Ign. Sep. —, cold or burning hot: *Sul.*
- , between 11 and 12 A. M.: **Numbness**, and rigidity here
Sul. and there: *Plat*
- Voice**, weak, faint and exhausted from talking: *Natr. mur.*
- Feeling**, of something in throat, which she has to swallow: *Lach.*
- Epigastrium**, tender to touch: —, and restless at night: *Sul.*
Hydr.
- Abdomen**, tender to touch; pull their dress or cover from off the: *Lach.*
- Feeling**, as of a tight band around waist, worse at night: *Hydr.*
- , as of a ball rolling in abdomen or in bladder: *Lach.*
- Pains**, recur about 3 A. M.: *Kali c.*
- Incarcerated flatulence**: *Lyc.*
- Pot-belliedness**: *Calc. c.*, *Sep.*
- Constipation**: *Plat. Pod.*
- , dry, lumpy feces, followed by matter like white of egg: *Hydr.*
- , and ischuria, worse during menses: *Aur.*
- Looseness**, inclined to: *Nitr. ac.*
- Urging**, unsuccessful: *Bell.*, *Lil. tig.*, *Nux vom.*
- Tenesmus**, constant, with frequent white slimy stools: *Ferr. jod.*
- Weight**, sense of, not relieved after stool: *Sep.*
- Slow**, difficult stool, although soft: *Sep.*
- Stool**, with blood during menses: *Amm.*
- After stool**, cutting in rectum for hours: *Nitr. ac.*
- Prolapsus ani**: *Pod.*
- Varicose**, on lower extremities: *Lyc.*
- Heavy sleep**, exhausts her: *Sul.*
- Sleepless**, before midnight: *Hydr.*
- Wakes**, after midnight and lies awake for hours; later heavy sleep with dreams till late in the morning: *Nux vom.*
- Wakes**, up very cross: *Lyc.*
- Feels bad**, after sleep: *Lach.*
- Chilliness**: *Puls*
- , and external coldness: *Plat.*
- Heat**, especially of first, which she uncovers: *Sul.*
- Tendency**, to perspire: *Merc.*
- —, about head: *Calc. c.*
- —, during motion and sleep: *China.*
- Cold sweat**, vomiting and diarrhoea: *Ver. alb.*
- Dryness**, and itching of skin: *Kali c.*
- Scrofulous diathesis**: *Calc. c.*, *Ferr. jod.*
- Weakness**, loses breath and speech: *Nitr. ac.*
- , from loss of fluids: *China.*
- Weak**, and tired: *Sep.*
- Nervous**, and hysteric spasms: *Ferr. jod.*
- After fright**: *Acon.*, *Ver. alb.*
- After straining**, lifting, parturition: *Arn.*, *Aur.*, *Calc. c.*, *Cham.*, *Nux vom.*, *Pod.*, *Rhus tox.*, *Sec.*

Desire , unsuccessful to urinate:	Worse , from bodily exertions:
<i>Bell., Lil. tig., Nux vom.</i>	<i>Calc. c.</i>
Urging , sudden, imperative: <i>Sul.</i>	—, from too long walks: <i>Rhus:</i>
—, frequent: <i>Cham., Pod.</i>	<i>tox.</i>
—, constant, with relief after passing water: <i>Hydr.</i>	—, from talking: <i>Calc. c.</i>
Ischuria , worse during menses:	—, from standing: <i>Lil. tig., Sul.</i>
<i>Aur.</i>	—, from touch: <i>China.</i>
The flow of urine , suddenly stops: <i>Con.</i>	—, from taking cold: <i>Calc. c.</i>
	<i>Calc. p.</i>
A few drops , are only discharged and some mucus from rectum:	—, at night: <i>Merc. China.</i>
<i>Bell.</i>	Climacteric age: <i>Lach.</i>
Scanty , deep colored urine:	Better , during menses: <i>Zinc.</i>
<i>Ferr. jod.</i>	—, when riding in a carriage:
	<i>Nitr. ac.</i>
Burning , and cutting in urethra after micturition: <i>Natr. mur.</i>	—
	After , the use of quinine and local application of caustics:
	<i>Natr. mur.</i>
Cough , at night when lying down and during pregnancy:	—, allopathic drugging: <i>Nux vom.</i>
<i>Con.</i>	

OBSERVATIONS ON THE TREATMENT, MEDICAL AND SURGICAL, OF ACUTE PERITONITIS.

The teachings of experience have so largely modified the views formerly held as to the tolerance by the peritoneum of surgical operations on the abdomen, that now, in some conditions of abdominal and pelvic viscera, it should be considered as culpable to allow a patient to die for want of proper surgical aid, as it was in former times to interfere with such treatment during the course of disease.

For this reason we give, in brief, a report by the *Medical Record* of a paper, on the subject of Acute Peritonitis, read before the New York Academy of Medicine, by Dr. T. Herring Burchard.

“Peritonitis might well be regarded as the most fatal of the acute inflammatory diseases. After a careful compilation of various hospital statistics, etc., its mortality

might be set down when all varieties of the disease were considered, at about from fifty to sixty per cent., and from twenty to thirty per cent. higher when so-called "idiopathic cases" were excluded.

"All treatment to rise above mere empiricism must rest upon a three-fold conception—a conception of the cause of the disease, a conception of the natural history of the disease, and finally the natural tendencies of the disease, or a foreknowledge of the mode of recovery or death.

"It would suffice to know that peritonitis might originate from *external traumatisms*, from *internal traumatisms*, by extension of inflammation from contiguous parts, from septic causes and certain blood diseases (as rheumatism, Bright's, etc), and possibly, though rarely, from causes that were purely miasmatic and climatic, constituting the so-called idiopathic cases.

"What were the causes of death? According to the textbook, collapse and asthenia. According to clinical and pathological observation, first, *collapse*; second, *asthenia*, which might be more intelligently expressed by (a) heart-failure, (b) respiratory failure; third, by inflammatory changes in the lungs; fourth, by inflammatory changes in the kidneys; fifth, by hyperpyrexia as a special cause super-inducing any or all the above.

"In no other disease was an early knowledge of the causation of the attack so essential. It was in the incipency of the attack, before excessive tympanites had disturbed the normal configurations of the abdomen and fatal asthenia had developed, that the golden opportunity for successful diagnosis existed.

"Under a systematically conducted examination, which necessitated the interrogation of each abdominal viscus, and which sought to find a satisfactory explanation for each abnormal symptom, it was surprising how the difficulty would disappear. It was to a want of thoroughness in the examination and a lack of the judicial element in weighing

symptoms, rather than to inherent difficulties, that the diagnosis often seemed so obscure.

"The diagnosis being made, and a local lesion amenable to surgical interference being demonstrated, surgical relief should be rendered at the earliest moment practicable.

"What, under the circumstances, were the indications for treatment? Were the irritation located elsewhere in the body than in this much-dreaded locality, sound surgical judgment would advise the immediate removal of the irritant. Why, then, should the peritoneum, a region which was daily proving its immunity to surgical manipulation by giving to surgery its brightest triumphs, not be subjected to the same wise principles that guided us elsewhere in our operative procedures?

"Dr. Burchard then referred to the paper read in this very hall, by J. Marion Sims (*British Medical Journal*, December 17, 1881), who sounded the keynote of the future treatment of such cases when he said, "Given a case of perforation of the intestines, and given an accurate diagnosis, which is by no means difficult, what are we to do in the present state of our knowledge? Why, of course, we should open the abdomen promptly, clean out the peritoneal cavity, search for the perforation, pare its edges and bring them together with sutures, and treat the case as we now treat other cases involving the peritonium." "Rest assured," he says, "that the day will come—and it is not far off—when an accurate diagnosis in such cases followed by prompt action will save life that must otherwise quickly ebb away."

"The point raised by Dr. James R. Wood, in the discussion on Dr. Sim's paper, to which reference had already been made, viz., that "pathological surgery, or operations done for tumors and disease, was very different in its result from traumatic or acute surgery, and that this was specially true regarding manipulation of a large serous membrane that resents all impertinent interference," did not, it seemed to him, afford a sufficiently logical basis for doing or not

doing the operation. As a clinical fact, the peritoneum was exceedingly tolerant of interferences, provided the proper precautions were observed.

"Dr. Burchard then read the histories of forty cases of laparotomy performed for injuries done to the abdominal viscera, either from external or internal violence, many of which were suffering at the time of the operation from acute peritonitis, including sixteen in which the operation was performed for the relief of acute peritonitis with purulent collections. The following is an abstract of the above cases: Laparotomies performed for internal traumatism, 21, with 12 deaths and 9 recoveries; laparotomies performed for external traumatisms, 3, with one death and two recoveries; laparotomies performed for peritonitis, 16, with three deaths and 13 recoveries.

"After which he read the history in full of his own case, which occurred in a man, twenty-six years of age, in whom an omental abscess burst into the peritoneal cavity during an acute peritonitis. Laparotomy was done, and the patient made a good recovery.

"If these forty cases with twenty-four recoveries teach anything, they teach not merely the feasibility of such operations, but, more than that, they give us legitimate ground for encouragement in fully sixty per cent. of these otherwise hopeless cases."

THE REST TREATMENT FOR MASTITIS.

Most physicians of experience have learned that in a threatening inflammation of the mammary gland, rest is the best single therapeutic agent which can be employed. The older methods, still advised, unfortunately, by some doctors and by many nurses and old women, of rubbing down the swelling, applying various liniments, and of persistently trying to empty the breast, can be very readily shown to be harmful and irrational.

Dr. Philander A. Harris has recently drawn attention to this subject (*American Journal of Obstetrics*) by a forcible advocacy of bandaging and rest in the treatment and prevention of mastitis. The conclusions drawn by the author are as follows:

"1. That the breasts soon after delivery are strongly disposed to secrete milk, and will usually continue to do so for a few days, even if they be not nursed. If no attempt be then made to nurse or withdraw the milk, the secretion rapidly diminishes and they return to their normal size and condition of inactivity.

"2. That, as a rule (to which there are probably few if any exceptions), the retained secretion does not undergo changes which convert it into an irritant fluid, but instead it remains innocuous to the walls of the ducts and acini which contain it, and under favorable conditions is finally absorbed without trouble or embarrassment to either the normal or inflamed adjacent tissues.

"3. That, as a rule, the secretion of milk continues only while the natural stimulus, as nursing or other means of emptying the breast, continue to be employed. That the secretion, either in the normal or inflammatory condition, begins to abate when such stimulus is withdrawn, and will entirely cease after a week or two.

"4. That an abundant secretion of milk which has recently and entirely ceased as the result of a complete withdrawal of stimulus, may be again recalled upon the reapplication of the child.

"5. That the presence of a decided inflammatory movement in the breast greatly diminishes secretion in the gland.

"6. That the sympathetic relation between the two breasts is almost, if not wholly, a sensory one. That neither the function of secretion nor the condition of the circulation in one breast is appreciably and directly affected by either physiological or pathological processes which may be going on in the other."

We would add that the pain and agony which are so vividly depicted by some writers as the inevitable consequence of mastitis are not always in reality excessive, the suffering being often as much mental as physical.—*Medical Record*.

SYSTEMATIC EXAMINATION.

Several years ago a bureau was started in Moscow (*Jahrbuch für Kinderheilkunde*), where wet-nurses could be examined by specialists with reference to old or recent syphilis. The examination was intended to be a very searching one, on account of the latency which characterizes this disease, and the possibility of future outbreaks in such cases. A certificate of immunity was withheld if suspicious glandular swellings, scars in certain places and of a certain character, suspicious pigmentations, or swellings of the bones were present, or if there was a history of repeated miscarriages. The condition of the nipples was especially noted. Of 490 women, who were examined in the course of three years, seventeen per cent. were refused certificates of immunity. In an additional four per cent. of cases the evidences of syphilis were unmistakable. It is gratifying to know that this bureau appears to have met with the approval of Russian physicians. But in our own country the establishment of such an institution is hardly practicable.—*Medical Record*.

SHORT STOPS.

ERGOTA.—From the report of the “clinic for midwifery,” at Prague, Bohemia, it is interesting to learn “that the use of ergot has been entirely discontinued, not one drop having been given in the past year, and the results are just as good. No after-bleeding occurs.”

CARDIAC WEAKNESS IN WOMEN.—Professor Suligmuller, of Halle, speaking before the last meeting of the German physicians at Madgeburg, held that this form of cardiac disturbance (“an expression of sympathy from some existing pathological condition in the system, or some definite organic lesion, there is a functional weakness of the heart, due to faulty innervation of that organ”) could always be traced to two causes, viz.: habitual sexual excitement without corresponding satisfaction, and continued intense brain work with insufficient allowance of sleep. Symptoms: general weakness, excitement and palpitation of the heart, pains in the epigastric region, profound reaction after even moderate physical or mental exercise, deepening occasionally almost into coma, persistent insomnia, hypochondriacal depression, failing nutrition in spite of good appetite, pallor and occasional formication in hands and feet. If we examine the heart at different times of the day we can always note the weakness of the apex-beat and the heart-sounds, and the smallness of the pulse.”

PLACENTA PREVIA.—Never rely upon ergot to control hæmorrhage, *time* is too precious. If the patient has had a sure flooding before your arrival, the sooner you deliver the better, more especially if you can have the assistance of labor pains. If head presents detach placenta on one side completely, so as to permit rupture of membranes, the head will, as a rule, become engaged. Do not introduce hand through the placenta; avoid, if possible, introducing the hand into the uterus for the purpose of turning. This procedure is always injurious to the mother and very apt to be followed by shock or severe inflammatory action. Reach an extremity with as little force and manipulation as possible. If time can be saved by plugging and hæmorrhage arrested it should be resorted to. It almost always stimulates the uterus, and the os will be more dilated. If the physician feels he should give ergot, see that the bladder is empty, os dilated, and the parts proportionable, and

his obstetrical forceps at hand. Remember it usually requires twenty to thirty minutes' time before the uterus responds to the physiological action of ergot. Can you afford to wait? If it is absolutely necessary to introduce the hand into the uterus, give an anæsthetic; it lessens the shock and prevents unnecessary pain.

SANTONINE IN AMENORRHŒA.—The allopaths are now employing this drug in two grain doses for amenorrhœa—especially if the patient presents any of the appearances of having worms. Proving of Santonine by a young lady: “Hæmorrhage from the uterus during the whole of the time that she used the semen santonica (in a girl of ten years). Labor-like, frequently recurring pains in the abdomen, as if the menses would appear.” In another case: “Menses too soon and profuse.”

OBITUARY.

Dr. Schwabe's Medical Journal, of Leipsic, brings us the sad news of the death of the last living association of Samuel Hahnemann's with this earth, Dr. Theodore J. Rückert, aged 85.

Dr. Rückert has for years been recognized as the senior homœopathic physician of Germany. Up to within a few days of his death he was perfectly vigorous in mind and body. He was one of the truest and most zealous believers in the principles of Homœopathy and the last of the immediate pupils of our Hahnemann. He, to the very last, took an active interest in the provings of his teacher. Dr. Rückert published several works, in German, among which was a valuable contribution on “Clinical Experience in Homœopathy.” He often quoted, when witnessing the crude homœopathy of to-day: “It mattered not to him; the acknowledgment of Hahnemann's science brought him his blessings.” We unite with his immediate friends and colleagues of Germany in closing, “*Rest in peace.*”

BOOK REVIEWS.

THE BOTANICAL ATLAS, A GUIDE TO THE PRACTICAL STUDY OF PLANTS, CONTAINING REPRESENTATIONS OF THE LEADING FORMS OF PLANT LIFE, WITH EXPLANATORY LETTER PRESS. By D. M'Alpine, F. C. S. Published by The Century Co., New York.

ZOOLOGICAL ATLAS (INCLUDING COMPARATIVE ANATOMY) WITH PRACTICAL DIRECTIONS AND EXPLANATORY TEXT FOR THE USE OF STUDENTS. 231 Colored figures and diagrams. By D. M'Alpine, F. C. S. Published by The Century Co., New York.

The comparative study of lower organisms leads by ultimate analysis to a better understanding of higher life. For this reason alone, if not for that of strengthening and enlarging the mind, we should advise the student of medicine, whose true desires are those of an earnest seeker after such knowledge as will best aid him in his chosen calling to pursue a thorough study of Botany and Zoölogy in connection with biology and anatomy.

Having thus acquired a knowledge of "first principles" of vital phenomena, we become prepared to investigate analogous structures and more definitely trace pathological effects to their causes.

Among the embarrassments and obstacles surrounding the study of Botany, the "Botanical Atlas" will be found an efficient aid.

The colored plates illustrate each plant or part of a plant in its natural tint, thus presenting to the eye of the student a representation of the flower in its appropriate garb. The dissection of flower, fruit and seed affords an introduction to a proper training of the eye and hand in the study of minute structures.

The "Botanical Atlas" presents in separate parts the sub-kingdom of Cryptogams, vegetable organisms propagated by spores, and the Phanerogams, plants producing true flowers and seeds.

We can especially recommend the classification at the close of the Phanerogams, as a saving of much labor in tracing a plant from a "group" through "class," "division," "sub-division," and "family" to the species to which it belongs.

The Zoölogical Atlas, "follows much upon the same plan, and deserves much the same commendations as the "Botanical Atlas," separate parts being devoted to the description of "vertebrates" and "invertebrates."

In beauty and style of illustrations it is not the equal of the work on Botany, but what it lacks in this direction is more than supplied by the aid the diagrams of dissections will give to the study of comparative anatomy.

Indeed, as a guide to practical work in examinations and dissection of animal life, it has no equal for accuracy of descriptions and illustrations.

We take pleasure in recommending these works and to call the attention of our subscribers to the fact that CHAS. ARNOLD, of Detroit, is the agent for the publications in this state.

THE AMERICAN HOMŒOPATHIC JOURNAL
—OF—
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NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal, should be exclusively for its pages; no others desired.
 2. Illustrations required for original contributions, will be furnished at the expense of the journal.
 3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
 4. Personal controversies, not being of interest to the profession in general can not be published. Explanations may be made through the editor. This rule will be strictly adhered to.
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THERAPEUTICS OF ABORTION.*

J. N. TAYLOR, M. D., Crawfordsville, Ind.

It would, perhaps, have better indicated the scope of this paper had I entitled it "Certain Therapeutic Measures in Abortion," with a sub-title indicating their use in excessive hæmorrhage in either avoidable or unavoidable abortion. This title would have been at once more modest than the present one, as well as more descriptive of the matter in hand.

As it now presents this subject, it assumes a knowledge of the restricted use of the term "Abortion," the various causes that lead thereto, the different degrees of liability at the various periods of pregnancy, and also a knowledge of the various degrees of danger to the pregnant woman, etc. It does not propose to consider the subject of sepsis after abortion from retained placenta, nor that peculiar state of

*Indiana Institute.

missed abortion, in which after the death of the foetus it is yet retained in utero and carried with but little or no inconvenience for weeks, even months, or at other times becomes a putrid mass from which issues anto-infection, and death from septicæmia. Nor yet does it attempt to deal with the various mechanical means of evacuating the uterus. It aims, at most, but to describe the dangers of abortion at a certain period, introduce a remedy, conceived to be of some importance, and so leave the subject.

That period embraced between the tenth and nineteenth week of utero-gestation is the one considered by obstetricians as most fraught with danger to the mother, and anxiety and trouble to the attendant.

Previous to this time, so slight is the vascular development of the uterus, so loose is the connection between the ovum and the maternal surface, that the one does not threaten a serious hæmorrhage, nor does the other offer an obstinate resistance to the efforts of the uterus at expulsion. From six months onward the process of expulsion is so nearly like labor at full term that from this stand-point it may be regarded as practically the same as far as the dangers and manner of dealing with it are concerned.

Thus, on being called to attend a case of threatened abortion, it should be the first care of the physician to ascertain, as nearly as possible, the stage of pregnancy. Should he find that it has not reached the tenth week, he may congratulate himself so far as any considerable danger to the mother is concerned; though, for the reasons above given, the danger to the ovum is still greater than obtains at the tenth week. Should his enquiries elicit the fact that the period of pregnancy lies between the tenth and nineteenth week, then, as has been before intimated, has he greater cause for anxiety and watchfulness, for the following reasons, viz.:

1. Because of the close anatomical relations between the placenta and the maternal surface, on which account it is much harder to detach than at any other period of pregnancy,

its detachment subject to greater delays and, *per consequi*, hæmorrhage.

2. To such a degree are the utero-placental vessels developed at this time that the tardiness with which the placenta is expelled, gives occasion for longer periods of hæmorrhage than occurs at any other stage of pregnancy.

It may be proper in this last connection to mention the fact that with some frequency it happens that, after the expulsion of the ovum proper, the pains cease, the os closes and the placenta is retained, sometimes for the space of eight or ten days, when the expulsive effort again resumes under great mechanical disadvantages, attended in some cases with alarming hæmorrhage, often much to the astonishment of the patient and physician.

After ascertaining the period of pregnancy, it should be the next care of the physician to determine whether or not expulsion is avoidable.

Conceive the patient placed in the recumbent position upon a shuck mattress, if attainable, or other hard bed if it is not, the foot of the bed elevated, the patient covered not too warmly, and directed to move just as little as possible, and that with great deliberation. The physician should then proceed to elicit the following facts:

1st. The character and rythm of the pains.

2d. The amount of hæmorrhage.

If the pains are unrhythmical, sharp and fleeting in character and the hæmorrhage slight, digital examination is not justified until sufficient effort has been made to control these symptoms. It is known, on the one hand, that the introduction of the examining finger is sometimes provocative of regular rythmical contractions of the uterus, where none such were present previous to the examination. On the other hand, it has been observed—indeed I observed it in one instance myself—that a trifling amount of hæmorrhage may persist for a number of days without the slightest effect being produced in the arrestment of gestation

(Leishman, page 364). Strictly curative measures may be addressed to this condition, and *Caulophyllum*, *Pulsatilla* or any one of the indicated remedies in sufficient strength be used for the purpose of allaying irritation and restoring the quiet and tone of the uterus. If, however, the hæmorrhage be considerable—the other symptoms of unavoidable abortion be lacking—the use of *Trillium*, prepared and administered as will be hereinafter directed, may be resorted to, until that symptom disappears, which may always be expected, with some confidence, if the ordinary hygiene of threatened abortion is observed, such as recumbent position, cooling drinks, light diet, etc., along with the *Trillium*.

If, however, the pains are rythmical, bearing down, assuming more and more of a tonic character, accompanied by slight chilliness and nausea, and if with these there be considerable hæmorrhage, the physician should at once proceed to make an examination, and commence at once the administration of *Trillium*.

The condition of the os is now of the first importance, and by it one issue of the case is determined. If found agape with a portion of the ovum protruding, or widely dilated, though the finger may not reach the ovum, abortion may be pronounced unavoidable, and measures at once taken to facilitate expulsion. If, on the other hand, it be found only slightly dilated, the cervix not encroached upon, there is yet hope of checking the process short of expulsion, though hæmorrhage and pain of an expulsive character may be considerable. The treatment should still be *Trillium* until the hæmorrhage ceases, when the first mentioned remedies may again be resorted to. With such a case as that last described confronting him—a case in which the pain and hæmorrhage are considerable, the os somewhat agape and apparently hastening on to complete dilatation and rupture of the membranes—with the friends, perhaps the patient herself, urging him to do something quickly, the physician is apt to resort to the “potency” of the indicated

remedy with fear and trembling; and though skilled in such matters, will, under existing circumstances, find some difficulty in summoning to his aid that coolness and power of abstraction necessary to enable him to group the symptoms presented around certain drugs, and thence pounce upon the one that has the strawberry mark upon the left arm. I presume, however, that if he be a sincere, pure Homœopath, according to the International's definition of the term, he will attempt to do this and so confound the demands for palliation with those of cure. The following illustration will make such an attempt luminous to the understanding of a "mongrel."

A child of six, in eating an orange, got a seed in his gullet, completely occluding the passage, so that even fluids could not be swallowed. The reason of the smallness of the calibre of that organ was on account of a stricture caused by swallowing the head of a phosphorus match some months previous to the present occasion. The efforts of his three physicians failed for some time to bring the seed up or force it into the stomach. In one of their consultations, pending further efforts, one of the physicians proposed the novel, not to say brilliant, expedient of administering pepsin with the view to digest the orange seed! A brother physician, somewhat given to irony, acquiesced in this suggestion and also proposed as an equally eligible alternative, the giving of some rich soil with the view to sprouting the orange seed, after which it might be pulled out by the sprout. The giving of potencies of Pulsatilla, Sabina, China and the like in the present case would, in the estimation of the average mongrel, prove as efficacious in removing its alarming features with due speed as the pepsin to relieve the blockaded œsophagus. This being the case, I know of no remedy that can more thoroughly challenge his confidence in such a crisis than Trillium rightly used. I was taught its virtues, how and when to use it, by an old physician in active practice who had used it for years with

the greatest satisfaction, and who declared that in material doses it was good against hæmorrhage of whatever character, but sovereign in post partum or threatened abortion.

If you have the fresh green root, prepare a decoction in the proportion of one ounce of the drug to the teacup of boiling water, suffered to cool. If you have a good reliable fluid extract—and there are such in the market—three drachms to the half teacupful of cold water will answer. Of either preparation, in the presence of profuse hæmorrhage, give a teaspoonful every ten or fifteen minutes until the flow is lessened; then lengthen the intervals and continue until the symptom disappears. When the pains are somewhat griping, the discharge bright in color, Tincture of Cinnamon bark may be used in alternation; ten drops to the teaspoonful of water may be given at a dose. A good domestic remedy, when none other can be had, is a teacup filled with equal parts of vinegar and cold water, into which is grated the half of a nutmeg; given like as in Trillium. This last has served its purpose and comes down to us from an old obstetrician whose name is now as forgotten as his prescription. Trillium, however, besides its manifest power over venous hæmorrhages, possesses the specific features of acting upon the uterus to relieve irritation and restore the natural tone of its fibre.

When the state of the os and cervix preclude the possibility of staying the progress of expulsion, paradoxical as it may seem, Trillium is yet good to promote the speedy and safe consummation of that end, chiefly, I think, through its power to change futile and distressing pains into yet more steady and strong expulsive ones as well as to control hæmorrhage. The consideration of mechanical interference, the use of forcible dilatation, placenta forceps, tampon, as well as the use of clysters, sedation, etc., I leave to be brought out in discussion.

CHRONIC DIARRHŒA OF YOUNG CHILDREN.*

From DR. H. GOULLAN, at Weimer.

The *Allgemeiner Homoopathischer Zeitung* contains the following article:

Dr. Hochecker, of Hildsheim, cured catarrh of the intestines with Calc. carb sixth and thirtieth in a few days. The child had been suffering for ten weeks; treated by two allopathic physicians. Enema of a few drops of Opium were given freely, which resulted in the most fearful spasms; they then gave Argentum nitricum with no better result. The child growing weaker day after day, in this way, it continued for ten weeks, when these two allopathic doctors informed the grief-stricken parents that they had employed every art their profession afforded without avail, and the child must die. Calc. carb. came to the rescue and the child recovered in a few days.

Another Case: A gentleman acquaintance of mine asked me to call and see his little boy, a child of four years of age, who had been suffering for months from a bloody phlegm-like evacuation. At times it would stop for two or three days and then return. The child was very weak and pale; tongue thickly coated, and one might well ask, what will this end in? After a rigid inquiry concerning the child's diet, I was told they gave him wine, and eggs every day, by advice of their family physician, "Medicinal-wrath" Herr Dr. B. The boy did not like eggs, but was forced to take them, for the doctor said eggs would certainly put him on his feet again. *Theory taught* him eggs contained a great deal of albumen, and this was what the child needed. I suspected at once this was the cause of the trouble. I gave strict orders not to give the little patient any more eggs; also left Mercur. corros.; the results were, that when so splendid and theoretical a diet was dispensed with

* Translations from the *Populäre Zeitschrift für Homoöpathie*.

the child recovered without giving one atom of the powders left. Moral: "do not cure all your sick over the same last." Prof. Jager makes the wise remark, "with some milk agrees and with others it does not;" and the same holds good with eggs. Children troubled with diarrhœa should not eat eggs, as they contain a specific poison in circumstances such as those mentioned.

[The old adage, that the nearer a man lives to a church the farther he is from God, seems applicable to our German Homœopathic Medical Journals with their clinical reports. The sacred soil of Hahnemann's native country—Germany—seems to be a good place for our American homœopathic physicians to go and do a little missionary work. The Germans certainly can stand proselyting to quite an extent. It would not be a bad idea to send over one or two copies of Hahnemann's *Organon*.—Ed.]

ABSTRACTS.

MASTURBATION IN THE FEMALE.

Uterine hæmorrhage may be due to congestion of the ovaries. If the congestion is marked, it may be the result of self-abuse. I do not think that this practice is by any manner of means as common in the female as in the male. There are several reasons why this should be the case. In the first place the genital organs of the woman are internal, and are not liable to the same irritation as are the organs of the male. Simple mechanical irritation will cause erection of the penis without any erotic feelings whatever. In the second place, by a wise provision of Providence, man is made the aggressive creature. If woman were the aggressive party, there would be very little virtue in this world. The passions of the male are as a rule much stronger than those of the female. This is seen in the lower animals, for the female often tries to prevent the approaches of the male. Another reason why the practice is not as common in the female as in the male, is that at the

present time there are very few women in a condition of typically good health, and therefore their passions are not so strongly developed. As I have said, I do not think the practice is as common in females as in males, still it does occur in boarding schools and also in our public schools. Not only are these habits practiced, but there have been circulated among the pupils of the public schools pamphlets of a pernicious character, as I learned when I was on the committee to look into the spread of this foul literature. We found that pamphlets of the most debasing character had been distributed in the public schools.

When masturbation has been practiced for any length of time, the evidencies can often be discovered by examination of the external organs.

Masturbation is not so readily accomplished in the female as it is in the male. Many females who practice this vice never reach the orgasm. It seems as though it were necessary that the whole vagina should be dilated and impinged as in the natural act. I have taken a good deal of interest in the investigation of this matter, and I have seen a number of cases where masturbation was practiced without the orgasm being reached, there being produced simply excessive excitement, the masturbator being obliged to desist from sheer weariness. This will explain why it is that when masturbation is practiced by the female it is carried to a much greater extent than it is in the male. I had a female patient who masturbated as often as eight times in a day. There is no male that could stand such a drain on the system. It would end in excessive prostration, spinal trouble, or insanity. In that case, in spite of the use of the largest doses of bromide of potassium, which is a specific for this condition, if there is a specific, in spite of all moral persuasion that could be brought to bear, the practice was continued. I applied cantharidial collodion to the whole vulva, producing a really cruel condition, but still the practice was continued. Under such circumstances the habit is a disease.

What does masturbation in the female produce? It will cause intense congestion of the ovaries, and this will lead to the same condition in the annex of the ovaries, the womb, for the womb is really an annex of the ovaries. The womb is simply a pouch, while the ovaries are something more than that. This may lead to the production of an ectropion of the lining of the canal, and on two or three occasions I have found it very difficult to decide between this condition and laceration of the cervix. In two or three cases the hymen was present. On looking at the part, it closely simulated laceration, and the test with the tenacula failed to reveal the nature of the condition, for the tissues were so infiltrated and soft that they could be brought together covering up the erosion. In these cases I am satisfied that masturbation was practiced.

What are the evidences of masturbation as revealed by an examination of the parts? In the first place the clitoris is much elongated, and the prepuce is hypertrophied and thrown into wrinkles. The nymphæ, which start from the clitoris and form the hood of the prepuce, from being rubbed become lengthened and thickened, and often there is more or less redness of the parts.—*Goodell in Medical Bulletin.*

ELECTRICITY IN OBSTETRICS.

Dr. W. T. Baird presents in the June number of the American Journal of Obstetrics, the following tabulated comparison of ergot with electricity:

ERGOT.	ELECTRICITY.
1.	1.
Action slow—no response until after 20 or 30 minutes have elapsed, thus losing time, thereby occasionally proving fatal to the patient.	Action instantaneous, thus economizing time, and so in some cases proving of great value to the patient.

2.

Action uncertain; in some instances it will entirely fail to produce uterine contractions.

3.

Action uncontrollable; it will sometimes "lash the uterus into a fury," which may produce laceration of the cervix or perineum.

4.

Action always followed by shock, and sometimes by great exhaustion.

5.

Action attended with danger, and always with an increase of suffering.

6.

Action continuous, allowing no time for rest, thus violating one of the wisest provisions of nature.

7.

It cannot be safely employed until dilatation of the os is well advanced; therefore its use is restricted to the latter part of the second and to the third stages of labor.

2.

Action certain; it need never fail to produce uterine contractions.

3.

Action under perfect control of the operator; therefore it may never endanger the integrity of the cervix or perineum.

4.

Action never followed by either shock or exhaustion.

5.

Action harmless, and always attended with a diminution of suffering.

6.

Action rhythmical, "giving ample time for rest," thus stimulating nature.

7.

It may be employed as soon as the first labor pains set in, and thus facilitates the labor in all of its stages.

Further on, in the same paper, the author gives the special indications for the employment of electricity as an oxytocic. He states that electricity may be deemed indicated in any case where it may be desirable.

1. To modify the pains of labor.

2. To favor a more rapid dilatation of the os.

3. To promote more vigorous uterine contractions.

4. To add tone and strength to all the muscles engaged, and "increase their power of doing work."

5. To abridge the time occupied by the labor.

6. To prevent shock, exhaustion, and post partum hæmorrhage.

7. To insure contraction of the uterus in cases of instrumental delivery.

8. To act as an auxiliary in the induction of premature labor.

9. To arrest hæmorrhage and accelerate labor in cases of placenta previa.

10. To prevent an undue expenditure of nervous force, in all cases of debility from whatever cause, thus leaving the patient in a condition to secure a speedy and favorable convalescence.

TRANSACTIONS OF THE BUFFALO OBSTETRICAL SOCIETY, WITH DISCUSSIONS.

Dr. P. W. Van Peyma read a paper on "The Management of the Puerperal Breast."

He first reviewed the anatomy of the female breast as requisite to a proper understanding of its histology and physiology.

The human breasts rarely exceeded two in number, though in a few instances supernumary glands have been observed. Supplementary nipples were less uncommon. These latter were situated a short distance from the principal one, were smaller, and yielded milk during lactation. In the lower animals, the number of nipples bore relations to the number of young at a birth; in the human family, this relation had not been traced. The developed gland was peculiar to the female, though in exceptional instances it had developed and secreted milk in the male. Secretion had been observed in the newly-born infant, and in the non-pregnant female.

The human breast was a racemose gland, composed of lobes, fifteen or twenty in number, these being sub-divided into lobules. Each lobule was formed of great numbers of acini or vesicles, opening into minute ducts. The ultimate ducts averaged 1-300 of an inch in diameter, which united

to form larger ducts, and these again united into fifteen or twenty canals, corresponding to the separate lobes. These tubuli lactiferi converged towards the areola, under which they became dilated into sinuses of 1-6 to 1-4 of an inch in diameter, and these continued, their lumen being contracted into the nipple, opening by orifices still more contracted. Connective tissue bound all these component parts together, acting as a frame-work and support to the blood-vessels, lymphatics, and nerves, ramifying through the gland. Involuntary muscular fibre was found in the duct walls; and it was arranged so as to form tissue analogous to the erectile tissue of the other generative organs.

The veins at the base of the nipple formed an anastomotic circle called the circular venosus, thence ramifying to the circumference, emptying into the axillary and internal mammary veins. The arteries were derived from the intercostal and thoracic branches of the axillary; while the lymphatics, in great part, ran to the axillary glands, a few passing through the intercostal spaces to the mediastinal gland. The nerves were derived from the internal and lateral cutaneous nerves of the thorax.

The tubercles at the areola enlarged during pregnancy, and secreted sebaceous material, which served to protect the surface. The histological appearance varied greatly between the conditions of secretive activity and quiescence. During, or just previous to lactation, the vesicles were composed of a net work of basement membrane, holding within its meshes from fifteen to twenty large polyhedral, usually pentagonal or hexagonal, epithelium cells, each containing a large nucleus, and occasionally a nucleolus. The cells of the ducts were pavement near their openings, but became more glandular towards the interior.

The embryological origin of the mammary gland was still an open question. It was commonly supposed to have had its origin from the ectoderm or epiblast, by a complex extension downwards, beginning in the fifth foetal month as

a solid rounded process from the mucosum. Creighton came to the conclusion that the secreting structure was formed in a layer of mesoblast beneath the outer skin, and that the ducts were essentially secondary formations, owing their existence to a force from within. But it was still a controversy whether the gland developed from a single center, or simultaneously from numerous points.

The physiology of the gland was limited to the maintenance of its growth, and the secretion of milk; and these two functions travelled much in parallel lines. The formation of milk was now known to depend on the activity of the large epithelial cells. Physically, this consisted in a process of vacuolation, by which the protoplasm becomes liquified, the nucleus pressed to one side, and after the formation of one or more globules, the liquefaction or rupture of the cell-wall and escape into the cavity of the acinus of the liquid cell contents. The result of this process, when at its height, was a collection within the vesicles and ducts of perfect milk. The formation of the perfect nucleated epithelium, whose activity and changes resulted in the production of milk, occurred only at the time of lactation, or a short period antecedent thereto. When the action of the cell was imperfect, as at the beginning or end of lactation, albumen was in excess of casein; but as long as the cell possessed its proper activity, the formation of casein became prominent. Casein, it had been suggested, might be formed by the splitting up of albumen by some fermentative process, but such ferment had not yet been isolated. That milk-sugar was also formed by the protoplasm of the cell, was indicated by the fact that the sugar was not dependent on carbohydrate food, but was maintained in abundance in the milk of carnivora when they were fed exclusively on meat, as free as possible from any kind of sugar or glycogen. We thus had evidence of the formation, by the direct metabolic activity of the secreting cell, of the representatives of the three great classes of food stuffs—proteids, fats and

carbohydrates—out of the comprehensive substance, protoplasm; and what we saw taking place in the mammary gland was probably a picture of what was going on in all protoplasmic bodies.

Were the fat of the milk not ejected from the mammary cell, the gland would become a mass of adipose tissue, especially if, by a slight change in the metabolism, the production of fat were exalted at the expense of the production of casein or milk-sugar. If, again, by a similar slight change, the milk-sugar were accumulated rather than the fat or proteid, we should have a result which, by an easy step, would lead us to glycogenic tissue. Finally, if the proteid accumulations were greater than the fatty or the saccharine, these being carried off in some way or other, we should have an image of the nutrition of an ordinary nitrogenous tissue.

The presence of nervous and muscular tissue in the breast, made the influences of the emotions over the quantity and character of the secretion of easy explanation.

The diseases of the breast of interest in this connection were numerous. The amount of secretion might be either scanty or profuse, and, strangely enough, the same general remedies were useful in both conditions. In proportion as the secretion became inordinate in quantity, the quality deteriorated; thus, this condition, as well as its opposite, was benefitted by generous diet and attention to the general health. In the former condition as well as in galactorrhoea pressure, by means of a sponge and bandage, the sponge being moistened with some astringent, as lead wash, etc., might be employed. Belladonna and camphor should be used with caution, lest the secretion be completely suspended. Among the diseases of the parturient breast, excoriations, chaps, and fissures of the nipples; obstructions to the flow of milk, and consequent engorgement; inflammation, and abscess were some of the most important.

The causes were varied. Among the more common were

exposure to cold, injury, and to the irritation of substances coming in contact with the nipple. Previous disease of the gland, and a low state of health, were predisposing causes. The prophylactic measures employed during pregnancy were well known. These included exposure to air, bathing, stimulating or astringent washes, suction of the nipples when too small, etc. Ordinarily, the child should be applied to the breast as soon as the mother had sufficiently recovered from the exhaustion of labor. Regular intervals for nursing should be maintained when practicable, without too arbitrary determination, at about three hours or less, with a gradual lengthening of the period as the age of the child increased. As a rule, weaning should not be postponed beyond one year from the commencement of lactation, and should be insisted on upon the occurrence of menstruation or pregnancy. Cleanliness of the nipples and the preservation of the general health were important prophylactics. A more or less general engorgement was not to be confounded with inflammation, to which it, later, might give rise. This quite common condition only required increased suction for its subsidence.

For the various abraded and fissured conditions, the nipple shield afforded an important means of relieving the strain of nursing. The intervals between nursing might be advantageously prolonged, by nursing the breasts alternately at protracted periods.

Inflammation of deep portions of the gland was often caused by extension from external fissures. Support of the breast was often an important consideration in prophylaxis. He concluded the essay by quoting the words of Dr. Harris: "There are probably few physicians who have not felt the need of more certain methods for averting inflammation and suppuration of the puerperal breast. The use of very gentle friction with oil, the withdrawal of milk in sufficient quantities to relieve distension of the glands, belladonna plaster, cold applications, hot fomentations, poultices, the

local treatment of sore or fissured nipples, or supporting the breast in a sling." The view that the retained milk, undergoing some fermentative change, acted as an irritant, was one very generally accepted. Physicians, therefore, generally agreed in the importance of relieving the breast; they were also equally agreed that the retained secretion soon became unfit as food. If, as was now claimed, these views were erroneous, the way was cleared to a very important advance in therapeutics. The injury resulting from continuous nursing was manifest. Dr. Harris, in the paper just quoted from, advocates a method of bandaging by which he supports the breast, and exerts gentle pressure at the same time. The nipple was left free, and the drainage of milk allowed to follow its own course. The patient, under this plan, required daily observation and an occasional re-application of the bandage. After a variable period, it was claimed that the inflammation subsided, when the child might be re-applied to the breast. Dr. H. supported these views by a report of cases. Of local blood-letting, the essayist had no knowledge. An abscess having formed, an incision at the most dependent point should be made. In the subsequent treatment of the cavity, besides general remedies, the bandage became especially useful in promoting more rapid contraction and healing.

DISCUSSION.

Dr. M. Hartwig spoke of the importance of studying the pathology of diseases of the breast, and said that the author's statement as to the nucleolus was new to him. Alluding to the curious anomalies in connection with this subject, he referred to the instance reported by Hyrtl, of a man's having nursed a child; and another where an infant suckled its grandmother. He thought the period of nursing should be lengthened, and believed it was proper to keep up breast-feeding until a child had sixteen teeth. He did not coincide with those who gave the child the breast early after delivery, but thought it better to wait three or four days.

He believed it was conducive to sore nipples for the child to constantly draw at the breast before the milk appeared. Abscesses were produced by germs entering the cracks or fissures, and not from distension of milk ducts by hypersecretion or failure to empty them. Abscesses were generally opened too late, or later than they should have been; though it was well not to commit the opposite error by opening them too early. The skin does not need to be red to indicate pus; so, too, there need not always be pain.

Dr. R. L. Banta referred to the treatment of mastitis as described in the paper of Dr. Harris, which aimed to secure rest from pain, secretion and motion. He had recently treated a case after this plan, but failed to obtain as much benefit as he had been led to expect from the cases reported in the article referred to. He believed that cases where abscesses formed were generally of the so-called scrofulous diathesis, and required constitutional as well as surgical and local treatment.

Dr. U. C. Lynde, present by invitation, said he had seen a case of development of the mammary gland in the male, but had never had the opportunity of observing a supernumary nipple or breast. Commenting on the pathology of diseases of the breast, he referred to the laws governing secretion and excretion, and thought the latter term should be confined to the elimination of effete material from the economy, such as urea by the kidneys, etc. In regard to the treatment of mastitis, he had employed nearly all plans, and he might say he had failed with all remedies on occasions, excepting the fluid extract of poke root. This drug he gave in ten drop doses every hour, and had come to regard it as a specific in the arrest of the suppurative process, and the control of pain. He did not think that mastitis always originated in the introduction of germs through the nipple-cracks. In regard to the practice of giving the child the breast early, he regarded it as beneficial to the child, and was not prepared to say that it was harmful to

the mother. There might, however, be cases where it would work perniciously in both direction.

Dr. A. Dagenais, also present by invitation, in commenting upon the treatment of the puerperal breast, said he was prepared to endorse all Dr. Lynde had said in regard to the use of poke root. He had, however, been in the habit of giving it in somewhat larger doses. These affections he regarded as often of the most perplexing nature to deal with, and any hints or suggestions which could be given were of great value. He looked favorably upon the support and elastic-pressure method of treatment, and also favored the early evacuation of pus in cases where suppuration took place.

The President had been much interested in the histological review which the essayist had given, but was in hopes to have heard more from the practical experience of the writer on the subject of treatment. He regarded it as one of the severest strains upon good nature or amiability of temper, to care for one of these cases when the infant, as would sometimes happen, obstinately refused the breast. To make the child finally nurse in such a case, was likely to solve the whole problem of health to both mother and infant. Among other things in the treatment of cracked nipples, he had found it a good plan to treat the child's mouth; for it would frequently be found that the salivary secretion acted as a poison or irritant to the raw tissues. This would prove important even though there was no stomatitis or other *apparent* disease of the mouth. It was his custom to direct the application of the child to the breast as soon as possible after delivery, that it might cultivate the habit of suckling at once; for it was often difficult to establish it after a few days of spoon-feeding. He did not see how this plan was more likely to produce fissures, and he thought it beneficial to the child to ingest the colostrum as soon as obtainable.—*Buffalo M. and S. Journal.*

ARTIFICIAL INFANT FEEDING.

Probably there is no subject in medicine that engages the attention of the general practitioner more than infant nutrition. In infancy the organs are delicately organized and hence more susceptible to unfavorable influences than during any other period. Professor Routh states, in his masterly work on Infant Feeding, that "among the most pernicious influences to young children, aside from colds, is improper food." A committee, of which Professor Austin Jr. was chairman, to raise the "dietary tables of the Children's Nurseries on Randall's Island" states, with much truth and force: "Children are not capable of resisting bad alimentation, either as regards quantity, quality, or variety. At that age the demands of the system for nourishment are in excess of the waste; the extra quantity being required for growth and development. If the proper quantity and variety of food be not provided, full development cannot take place, and the children grow up if they survive, into puny men and women, incapable of the ordinary amount of mental or physical labor, and liable to diseases of various kinds."

No artificially prepared food is a perfect substitute for mother's milk, and hence artificial feeding of the infant, unless under the most favorable circumstances, results disastrously. Cow's milk, which is not so alkaline as human milk, is therefore more readily rendered acid and if not properly fed the food, from its acidity, produces colic and diarrhoea. From the report of Dr. Mayer of Berlin, on the analysis of the milk of a large number of cows, we learn that of forty cows fed on potatoes, mash, barley husks, clover hay, and straw, in ten which were examined, the milk was sour and in three very sour. From among fifty cows fed on potato peelings, wild hay and barley straw, in all the fresh milk was sour. Afterwards out of forty other cows, fed on the same kind of food, the twelve selected for

examination showed all the samples of fresh milk to be sour. From six cows fed on garden truck, such as beets, potatoes, hay and bran, the samples were slightly sour. While in milk from five cows fed on warm bran mash and hay, the examination showed that the milk was quite neutral and in one it was alkaline. The above report of Dr. Mayer shows that the quality of cow's milk can be regulated to a marked extent by proper feeding.

Without attempting to enter into a discussion as to the *causes* that led to artificial feeding of infants, we will consider what we have at our command for that purpose. Cow's milk we have already spoken of with the objection to its use, and this objection must be emphasized especially if the animals are stall fed, as most of them are in larger cities. There is much deceit in the sale of milk, the delivery wagons being variously decorated with rustic names such as Riverdale farm, Meadowside creamery, etc., etc., (with headquarters in some side alley down in slums of the city) would lead one to believe them loaded with extract of a country fed bovine, instead of death-dealing lacteal fluid. Then there will be found "the babies milk can" supposed to be "one cow's milk" or "Jersey cow's milk," but the chances are that the contents of this can came from the general supply.

Following cow's milk we have various preparations of food including Nestle's Lacteous Farina, Liebig's Soup, Horlich's Food, Ridge's Food, Anglo-Swiss Milk Food, Murdock's Liquid Food, Mellin's Food and innumerable others all having their advocates. But there is one preparation not referred to that is, we think, superior to all of those named on account of its close resemblance to human milk; it is the "Peptogenic Milk Powder." Prof. Albert R. Leeds, chemist at Hoboken, New Jersey, gives the following analyses of 80 samples of woman's milk and then makes a comparison with the results obtained from the action of "Peptogenic Milk Powder" upon cow's milk.

Analyses of 80 samples of human milk.				Cow's milk after action of milk powder.
	Minimum.	Maximum.	Average.	
Water	83.21	89.08	86.73	86.2
Fat	2.11	6.89	4.13	4.5
Milk sugar	5.40	7.92	6.94	7
Albuminoids	0.85	4.8	2.00	2
Ash (salts)	0.13	0.37	0.20	0.3

The change in the cow's milk is accomplished by the action of the pure digestive principle contained in the "Milk Powder." This milk in the stomach or upon addition of an acid forms the minute soft flocculi characteristic of human milk and appears strictly analogous, on comparison of the analyses, in all its properties and qualities to normal human milk. The problem has always been how to increase the digestibility of the caseine of cow's milk, and we are indebted to Professor Pfeiffer for the valuable idea of peptonising the milk, by which the caseine is physiologically changed into a readably soluble peptone.

Cow's milk thus treated becomes thinner and bears a closer resemblance to human milk, while even if the caseine is not all digested that which remains coagulates in loose flakes.

To sum up these we would say:

(1) Cow's milk can be in no sense a substitute for woman's milk except it undergoes a modification by chemical processes, so as to make it physiologically equivalent to human milk.

(2) That the indigestibility of the caseine of cow's milk is universally recognized as the chief obstacle to the employment of cow's milk as a food for infants.

(3) That we now have given to us, through the efforts of those who have devoted many years to the subject, a physiological method by which the caseine may be so changed and the milk so modified that comparative analyses show the result to be, not merely a mechanical but a true physiological substitute for human milk.

(4) The use of this peptonized milk is not urged upon a basis of demonstrated facts alone but also upon the conclusion that must be drawn from the good results of its employment in artificial feeding; that is, our deductions from experience the most trustworthy of teachers.

INSPECTION OF THE NEW ENGLAND HOMŒOPATHS.

BY THE EDITOR.

Accepting an invitation from some of the members of the Massachusetts Homœopathic Medical Society, to attend their semi-annual meeting in Boston, October 14, we laid aside professional cares and anxieties and took up our line of march eastward. We landed in that delightful old historical and puritanical city, Boston, amidst rain and mud, but the hospitable reception of the genial Phillips more than compensated for our discomfort. When the Boston people undertake to do anything on the grand scale, a guaranty in writing is not necessary that it will be well done; no sir, one can go to bed with full assurance that it will be all right. A meeting of their medical society was no exception to the general rule. We (out west) now know why the American Institute has its Wesselhoefts, Talbots, Phillips, Clarks, Bennetts, and a host of other good fellows, for their local societies are made up of just such material all the way through.

On the following morning we reported ourselves with proper credentials from the Michigan State Medical Society and the College of Physicians and Surgeons of Michigan at the Y. M. C. A. building and received from the President the usual courtesy—so precious to the heart of the average American—the privileges of the floor. When an American physician is handicapped in his speech at a medical society, his interest soon flags and he can be counted on for a vote “that it was a failure.”

The meeting opened with but little formality and the different bureaux made their reports with promptness. The *personel* of this society was above the usual State associations and made the Western visitor's heart swell with pride as he looked about upon the intellectual faces of the members. From the programme we learn that the officers for 1885-86 are C. I. Nichols, M. D., of Worcester, President; F. H. Krebs, M. D., of Boston, and F. B. Perry, M. D., of Brookline, Vice-Presidents; J. Wilkinson Clapp, M. D., Boston, Cor. Sec'y; P. W. Emerson, M. D., Dorchester, Rec. Sec'y; H. C. Clapp, M. D., Boston, Treasurer. When the Bureau of Materia Medica made its report, the chairman, C. Wesselhoeft, M. D., treated us to an excellent article on "provings," or as the writer preferred to call it, "experimental trials," with an abstract of proving of *Xanthoxylum* by several lady students at the college. The general verdict seemed to be that this drug had a special affinity for the left ovary, and for certain forms of ovarian dysmenorrhœa and ovarian neuralgia should prove beneficial, especially when the patient had a rheumatic diathesis.

The event of the day was the report of the Bureau of Gynæcology, H. K. Bennett, M. D., Fitchburg, chairman. The first paper "Influence of the Ovaries in Health and Disease," was read by Adeline B. Church, M. D., Boston, and the subject was more than well presented. The writer left nothing undone, and gave some interesting statistics. Owing to the limited range of her subject as fixed by time, the matter had to be given somewhat in the form of an abstract. Boston has always boasted of her women, and if Dr. Church is a fair representative of her sex, the city has every reason to be proud. "Medicine vs. Surgery," by Dr. H. K. Lougee, of Lawrence, came next. The writer although placed in a somewhat embarrassing position, by having this subject assigned him, labored manfully with his effort, and had the society not been limited as to time, would, no doubt, have brought out a sharp and interesting discussion.

The paper on "Laparotomy for Diagnostic and Therapeutic Purposes, with three cases of Ovariectomy," was read by its author Dr. A. Boothby, of Boston. The subject, as presented was more of an abstract, and as the writer stated, he presented it with the object of drawing out a free discussion. Dr. Boothby is working in the direction of abdominal surgery, and therefore advanced some practical ideas. We sincerely hope the doctor will keep pushing on in this, comparatively speaking, new field of surgery. There is a growing demand in our school for an abdominal operator in every city. Other papers were read by title and accepted.

Oration. What *can* we say, regarding this grand rendition of deep and fully matured thought, gathered by the wayside, treasured up and delivered before this society; it was indeed "a feast fit for the Gods." Why haven't we more Wesselhoefts? The orator for the day was Wm. Wesselhoeft, of Cambridge, Mass., and his subject, "Rationalism in Medicine." While listening to this intellectual production we became so interested that "notes" were forgotten, and we refer our readers to Dr. Clapp the secretary, for a copy of the paper when it is published. At the close of this literary repast the well known voice of Dr. I. T. Talbot was heard from the rear of the hall, addressing the chair, and calling attention to the fact that "while Dr. Wesselhoeft's address was just 'the right thing in the right place,' nevertheless the fact must not be lost sight of, that it was some time past the intermission hour for lunch and our inner man must be considered." After refreshments in an adjoining room, the discussion of papers previously read, took place.

The Bureau of Surgery was represented by Dr. Horace Packard, of Boston, chairman, and ably supported by Drs. Warren, Jackson and Foss. The last gentleman introduced some peculiar ideas regarding the subject of "the healing of large surface ulcers without the use of skin grafting."

Space forbids a full report of the different bureaus, but suffice it to say that with the report of the Bureau of O. and O., closed one of the most interesting state societies we have ever attended. We desire to call attention to a portion of the by-laws of this society, as it explains our views of the "Objects of Medical Societies."

"This society demands for itself absolute liberty in science, and hence requires of its applicants for membership no creed or confession of medical belief, but only the expression of a willingness to act for the furtherance of its declared objects." That is broad enough for any school of medicine, even the old code Allopaths—guess Brother Talbot had a hand in the framing of that section.

The following day your visitor under the guidance of Dr. I. T. Talbot, thoroughly inspected the *Massachusetts Homœopathic Hospital*. To say that it is a magnificent building in all its appointments would be an inadequate description, and yet we can only give a cursory report. The original building, constructed in 1876 at a cost of \$80,000 could accomodate only forty patients, but, by degrees, additions were made, until now they have a grand structure—a fitting monument to Hahnemann and his followers. Their ovariectomy ward is isolated and is as thoroughly protected from the general hospital as if erected on separate ground. The cottage for contagious diseases—a gem of architectural skill—was next visited and admired. Special attention seems to have been given to ventilation; the old fashioned fireplaces were seen in each ward, private and public. We were now conducted to the college building, adjoining the hospital, which was pronounced complete in all its details. The free dispensary is run in connection with the college and affords ample clinical material. The surgical amphitheatre is a model in arrangement, and well adapted for operations, including gynæcological cases; special regard to good light entering largely into its construction. Before leaving our guide, we could not resist passing an

encomium upon the combined institution of learning, and add with pleasure that it is not surpassed in this country. With our guide we then proceeded to Bunker Hill, Boston Commons, and other places of historical interest. We closed our visit with a meeting of the Boston Gynæcological Club in the evening. Here we were again treated to an exhibition of what a number of physicians can do when gathered together for the express purpose of advancing the science of medicine in a certain direction. This society believes in "quality, not quantity," for their membership is limited to fifteen. Dr. H. K. Bennett is president, and Dr. L. A. Phillips secretary, and this band of earnest workers are doing a grand, good work in their special line of study. We desire before leaving this subject, to acknowledge our thanks to all who contributed to our unexpected entertainment, and especially do we wish to express our debt of gratitude to Dr. and Mrs. Phillips, and Dr. and Mrs. Talbot, for courteous and unremitting attention during our stay in Boston.

From Boston to New York is but a step, and on the following morning we were calling on friends in the metropolis. On our way over to New York, by the Fall River line steamer, we had the good fortune to meet Drs. Clarke, of New Bedford, Mass., and Heber Smith, of Boston. The latter gentleman was making an effort to run away from a severe attack of gout. Yes! actually the gout, and a down east yankee at that.

NEW YORK.

By special invitation our first call was upon Mr. A. L. Chatterton, the energetic publisher of homœopathic medical books and journals: Dr. Geo. W. Winterburn, the wide-awake editor of the *American Homœopathist*, was next run down and "interviewed" for professional news. George is always primed on matters of general interest, and gave us some facts and figures regarding our school in New York that were interesting.

"To begin," said our informer, "we have three hundred and eighty-five homœopathic (so called) practitioners in this city; two hospitals, run somewhat on the close communion order, however; two medical colleges; nine dispensaries and three medical journals." The New York Medical College supports some thirty-three professors. Among the faculty we find the well known names of T. F. Allen, J. W. Dowling, Wm. Tod. Helmuth, L. L. Danforth, S. D. Talcott, of Middletown, and C. T. Sterling. With the other members we are not personally acquainted, but take it for granted they are well up in their respective chairs.

At the solicitation of Dr. Helmuth we visited the Hahnemann Hospital and found the wards well filled, and saw several interesting surgical cases of his handiwork. The ovariectomy cottage—a special pet of Helmuth's—we found perfect in every particular. The ward was, at the time of our visit, occupied by a patient that had successfully passed the severe ordeal of an ovariectomy, and in the general hospital wards several were convalescing. From honest statistical reports and for other good and sufficient reasons, we take pleasure in acknowledging Prof. Wm. Tod. Helmuth as *our* ovariectomist. To him only should this honorable title be given. His noble and unselfish work in this field of surgery, with courteous treatment of others who are laboring in the same direction, compels us to accord him this recognition and distinction; wish we had more men like Helmuth, Allen, and Dowling in New York. While making our rounds we had the pleasure of meeting Dr. L. L. Danforth, editor of the *Obstetrical Journal* and professor of obstetrics in the New York Homœopathic College. Full of enthusiasm and energy, the doctor represents a part of the young blood and sinew that now characterizes the activity of our New York Homœopaths.

After doing the Brooklyn Bridge and a few of the numerous points of interest in this truly great city we returned home, feeling we had been well paid for our week of vaca-

tion, and with the proud satisfaction of knowing that the homœopathic profession was a willing supporter of a higher medical standard among its practitioners and an earnest advocate for the elevation of the grandest of all professions.

THE AMERICAN OBSTETRICAL SOCIETY.

An association of medical practitioners was organized October 28th, and incorporated under the laws of the State of New York with the object of engaging in the systematic study of the art and science of obstetrics. For this purpose it is deemed desirable to include within its membership every physician who is especially interested in the development of this department of medical practice. The society has already seventy-nine members, located in twenty-one States, with the following officers elected to serve until the annual meeting in June next:

President, Geo. W. Winterburn, M. D., of New York; Vice-Presidents, Henry Minton, M. D., of Brooklyn; Prof. Sheldon Leavitt, M. D., Chicago; Prof. Walter Wesselhœft, M. D., Cambridge, Mass; Secretary, Everitt Hasbrouck, M. D., Brooklyn; Treasurer, Clarence M. Conant, M. D., Orange, N. J.

Meetings will be held as often as practicable, the first of which will be in New York, December 10th, of which further notice will be issued. The annual meeting for 1886 will be held at Saratoga, in connection with the meeting of the American Institute.

The annual dues are two dollars for the first year (this includes the certificate of membership), and one dollar for each subsequent year. It is hoped that plans for an equitable dissemination of papers and discussions may be evolved which shall promote the largest benefits to the membership. The transactions of the society, including all the papers and a stenographic report of the discussions will, for the

present, be printed in full in the *Homœopathic Journal of Obstetrics*.

A cordial invitation is extended to any one interested in the objects of the Society.

E. HASBROUCK, Sec'y., 253 13 St., Brooklyn, N. Y.

SHORT STOPS.

LIVER SPOTS.—This annoying trouble, known as *tinea versicolor*, yields readily to sulphur. A good preparation is the hyposulphite of sodium, one drachm to the ounce of water, applied locally. (If you fail, try similia.)

BÖECKEL AND ROBERT claim that erectile tissues of the genital organs of the female are not confined to the walls of the vagina clitoris and uterus, but is found in the extremities of the Fallopian tubes and in the rings of the ovary.

IN referring to *Damiana* and its action on the erectile tissue of both sexes, a writer makes this truthful statement: "Reduced sexual power, from whatever cause it may arise, is one of the most distressing maladies, and is, therefore, entitled to the deepest sympathy and consideration on the part of the honest practitioner, by whom, unfortunately, it is rarely discussed."

BOOK REVIEWS.

BODILY POSTURE IN GYNÆCOLOGY. By S. J. DONALDSON, M.D., New York. Reprint from the *American Journal of Obstetrics and Diseases of Women and Children* Vol. XVIII, No. 5, 1885.

The writer presents some sensible deductions from his arguments his advice on postural treatment is so practically demonstrated from an anatomical standpoint that we heartily endorse it. Too little attention is given this subject by our gynæcologists. We wish, however, to give the author some advice. When he has anything to say or write that he thinks especially good, let him publish the same in some homœopathic journal. Don't cater to the editors of allopathic journals, for their subscribers.

THE AMERICAN HOMŒOPATHIC JOURNAL
—OF—
GYNÆCOLOGY AND OBSTETRICS.

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NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal, should be exclusively for its pages; no other desired.
 2. Illustrations required for original contributions, will be furnished at the expense of the journal.
 3. Business communications, subscriptions, etc., should be addressed to the publisher, at Ann Arbor, Mich.
 4. Personal controversies, not being of interest to the profession in general, can not be published. Explanations may be made through the editor. This rule will be strictly adhered to.
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A SINGULAR CASE.

D. M. NOTTINGHAM, M. D., Lansing, Mich.

Mrs. M——, aged 36, is plethoric and healthy in appearance, and presents the following history and symptoms:

When eighteen years old she was assisting to carry a stove up a stairway. In her effort to lift she felt as though something had given away about her hips. A severe pain followed from which she seemed to recover after a few days confinement to bed. Following this she was attacked immediately preceeding the menses with a pain similar to the one experienced after the accident. It would come on very suddenly like one heavy labor pain, lasting for from ten to thirty minutes. This continued until she married and became pregnant, at which time the pain entirely ceased and did not return until she began to menstruate again, when it returned and continued as before, until second pregnancy. During second pregnancy the same results

followed and did not return until menstruation was again established.

She became pregnant the third time, which resulted in an abortion at the third month. After the abortion the pain again appeared, but this time coming midway between the menstrual periods. At this time she would be seized with the most severe "labor-like" pains, lasting about twenty minutes, followed by extreme prostration and soreness over whole abdominal region. After about twelve hours she would feel as well as ever again. At the menstrual period she had no pain. When I first saw the lady she had been in this latter condition for about three years and during this time had not missed a month without experiencing this most uncomfortable symptom. During this time she had been treated for nervous prostration, neuralgia, uterine displacement, etc.; but had received no relief.

Upon making a local examination I found the uterus in proper position, except slightly prolapsed. There was congestion of the cervix. Upon passing the sound she experienced a pain similar to the pain felt at the time spoken of, except not so severe. I at once concluded that the trouble lay somewhere within the cervical canal. I began treatment by the use of uterine bougies, passed within cervical canal. Upon passing these or the sound into the canal, she would be sure to have a pain follow. I consequently began the passing into the canal a Nott's dilator and gradually dilated the canal to the fullest extent of the instrument. While doing this she was worse than she had ever been; having a pain sometimes every day and always after each operation. I finally ceased the operations and to my happy surprise the pains entirely ceased and have not since returned. I do not consider her entirely cured, for if she is upon her feet a great deal she has symptoms of the pains.

I have never been satisfied as to what was the actual

cause of these pains nor of what I have relieved. I have been unable to procure literature upon the subject and report this case in the hope of obtaining some light.

NOTE BY THE EDITOR:—The case referred to by Doctor Nottingham is evidently one of those conditions, obscure and often difficult to differentiate, and which I have named as fissure of the cervical canal or of the internal os-cervico-uterine fissure. In my experience, I am satisfied I have met with several instances wherein every symptom pointed to no other pathological state save that of a fissure and the treatment based upon this conclusion, demonstrated my claims to this diagnosis. Doctor Nottingham's complaint of a want of literature on the subject or any light that would assist him in working out a theory is an universal one. There is nothing that I have seen touching upon the question. Fissures are simply a solution of continuity, or cleft of the superficial tissue, found, usually, at the anus, lips, urethra or vesico-urethral portion more often, but confined generally to mucous membranes and the skin, *and why not in the cervical canal or at the internal os?* I have met with cases where there were all the well known characteristic symptoms found associated with fissure in other parts of the body and by resorting to rapid dilatation with a divulsor, the patient obtained permanent relief. The symptoms I regard as peculiar to fissure of the cervical canal or internal os, are, first, during menstruation, after the flow has been established, severe spasmodic pains, at times, labor-like in character; the two elements of pain and spasm being the principal indication, developed by the energetic and painful contractions of the uterus. A cicatrix in the canal or within the uterus, the result of a laceration or an inopportune, barbaric treatment, known as cauterization, will produce similar symptoms, but the uterine sound will easily differentiate between this condition and a fissure. The seat of the contraction is usually at the internal os, and by passing a fine probe, during menstruation, up to the fissure the uterine pain can at once be brought on. In those cases where there is no pain during the menstrual epoch it is explained by the fact that the patient is not of a neurotic diathesis or her vitality not impaired, and the uterine tissues being erectile in nature, to a more or less extent, the organ becomes tumified with blood; the calibre of the cavity and canal increased, thus for a time spreading out, as it were, the cleft or fissure, or rendering it less sensitive to the presence of the

menstrual flow. Second, during the inter-menstrual period the patient will experience, at times, severe uterine spasms, produced by the presence of an extra amount of mucus in the canal, irritated by pressure, or its chemical composition; the delicate sensitive ulcer producing a tenesmus or contraction of the uterus that will expel the secretion and at the same time leave the patient very weak and prostrated. Third, some constitutional trait that would justify a physician in anticipating a condition of this nature when other symptoms correspond. Fourth, severe pain-spasmodic in character, when the probe or uterine sound is passed over a given portion of the cervical canal, or through the internal os, which ceases, in a moment after this point has been passed, but the pain returns again, soon as the instrument is withdrawn to the location of the fissure. The introduction of plain cotton dressing on an applicator will, when it reaches the point of the fissure, produce the severest pain. The condition is peculiar to women who have borne children or had miscarriages.

My method of examining cases of suspected fissure is conducted with two purposes in view; first, to locate the cleft; second, to ascertain its length. The first, to know how far, internally to introduce the points of the divulsor, and the second to decide upon the amount of dilatation necessary to completely destroy the continuity of the tissue about the fissure. The greater the length of the cleft, the greater the dilatation in order to accomplish a cure. I employ a utero-metric sound with an acorn shaped bulb on the point which can be removed at the will of the operator. I pass this instrument up to the point where the patient first experiences pain, and with the indicator on the shaft of the sound I make a note of the depth it has entered; then forcing the sound beyond the sensitive point, I wait a few minutes and then withdraw the instrument until the abrupt shoulder of the tip comes in contact with the upper portion of the fissure, a record is made again by consulting the figures on the shaft and the length of the fissure determined by the distance between the first and last figures. This method I also employ when ascertaining the length of a stricture, from scar tissue or other cause in the cervical canal or within the cavity of the uterus, except that I use a small sized bulb, one that will pass the obstruction, and yet meet with some resistance as it is withdrawn, on account of the peculiar shape of the tip. After making an examination of the distance the sound is in the uterus or canal, I forcibly withdraw the instrument and change the tip for a larger size which can be passed up to, but not through the

obstruction. The distance between the upper part of the stricture and its base can be readily ascertained and the surgical treatment carried out much more satisfactorially than without a knowledge of the tried pathological condition.

The surgical treatment for relief from a fissure is simple, and yet, if not thorough, temporary relief is only obtained. Dilatation is the only method I employ. At first I used Hank's hard rubber uterine dilators and then changed to Heyward Smith's steel sounds, but the treatment was not as satisfactory as I wished, and I found Nott's, Schultz's and Peaslee's instruments constructed of too light material to thoroughly dilate the canal. If there was any special resistance on the part of the circular fibres of the cervix, the handles of these dilators would spring together without dilating the parts to any extent. I then had made a large trivalve divulsor, (after Sim's) which gives complete satisfaction. One serious objection to employing the bougies or the ordinary uterine dilators, is the number of times this gradual process of dilating, compels the patient to undergo suffering. With the other method, employing an anæsthetic and completing the operation at one sitting, robs it of the terror and dread that follows the gradual method of dilatation. I carry the dilatation to a point corresponding to the length of the fissure, being careful to completely efface all traces of the fissure by destroying the mucous membrane at the point of the fissure. Before introducing the beak of the divulsor, the anterior or posterior lip of the cervix—according to the position of the patient; the dorsal or lateral, should be firmly grasped by a pair of blunt pointed vulsella and the uterus brought well down. By this, I mean, to bring the organ within view; to change the normal axis of the womb to one corresponding to that of the vagina, and at the same time not to lacerate or injure in any way the connective or cellular tissue of the pelvis. The connective tissue, the main support of the uterus, is susceptible of being stretched to quite a degree, owing to its elastic nature, but beyond this point it is dangerous to the patient, to carry the womb. The divulsor should then be carried up to and just beyond the internal os and force used until the proper amount of dilatation has been accomplished. Soon as all hæmorrhage is controlled, I dress the canal with a pledget of arnicated cotton. At first I employed plugs made of slippery elm, then glass, but often found the uterus intolerant of their presence, and now I use only cotton that I introduce on the applicator. It is also a good plan to fasten a stout thread to the pledget to assist in its removal without giving any unusual amount of suffering to the

patient when dressing the tender and indurated cervix. Another precaution should be observed, and that is to keep the cervical canal as clean as possible; at least dress the parts once every twenty-four hours for the first week. The lymphatic glands of the uterus are, as a rule, very active, and I deem it of sufficient importance to keep the contused tissues free from all septic matter as possible after any operation that leaves an exposed surface.

The after treatment consists in restricting the patient to her bed, for ten days or two weeks, according to her previous condition, as this operation, which may appear a slight affair, can produce a severe attack of metritis or peri-uterine cellulitis. There is a limit to the toleration of the uterus—a much abused organ—in surgical treatment; to-day it may submit, without protest to harsh manipulation; to-morrow the slightest operation will be sufficient to light up the severest form of an inflammation. The medical treatment for cervico-uterine fissure is as yet undeveloped—My experience with such remedies as *Graph.*; *Nit. Acid.*; *Pæonia*; *Sulph.*; and others, have not, in a single instance, relieved the patient; but I have not one failure to report, after the mechanical treatment with the divulsor.

Later on I shall report some ten cases treated by this method, giving the peculiar characteristic indications of each case.

CASE OF CÆSAREAN SECTION AFTER DEATH OF MOTHER —SUCCESSFUL.

BY J MACK HAYS, M. D., Oxford, N. C.

A short while after eight o'clock on the evening of October 3d, I was hastily summoned to the wife of Mr. C——, living seven miles distant. On reaching the house I was informed that the patient was too far gone for me to do her any good. The following history was briefly given me: About four hours previously Mrs. C—— was in the yard looking after her domestic affairs, and enjoying, apparently, her ordinary good health, when she was suddenly attacked with a violent headache and sent in haste for her husband, at the mill, a hundred yards distant. When he reached the house she told him to send at once for the doctor, as she

felt very sick, and her head hurt her terribly; then throwing her hands to the back of her head, fell on the bed with the exclamation, "I can't stand it!"

She was speechless from that moment, vomited frequently for some little time, several times threw her left hand to her head, and sank rapidly into the condition in which I found her. She was evidently suffering from an extensive cerebral apoplexy, presenting the following symptoms: Complete motor and sensory paralysis of left side of body; both pupils widely dilated and totally insensible to a bright light; very slow, stertorous breathing, and "drawing in of the paralyzed check with inspiration, and its puffing out with a sort of explosion in expiration." pulse rapid and barely perceptible; face pallid. A sharp pinch on the non-paralyzed arm produced no evidence of sensation, nor did the hypodermics of whiskey which I administered as a forlorn hope. The patient was rapidly approaching her end, and was eight and one-half months advanced in pregnancy.

I satisfied myself from the husband that the child was probably alive, as he had heard his wife speak of having felt quickening the same day. I then laid the case clearly before the husband, telling him that while one life was fast passing away, another was at stake which might be saved even after the mother had breathed her last. He told me to do as I thought best. Accordingly I made the necessary preparations, and after all evidences of life had disappeared in the mother, and the bystanders sent out of the room, I proceeded without delay with the operation. With one stroke of my scalpel I incised the skin and subcutaneous tissues from the umbilicus nearly to the symphysis pubis; two incisions more, through the linea alba and peritoneum, exposed the uterus to full view; through it I next made an opening as low down as possible, and of sufficient size to admit my two fingers, at the same time liberating the liquor amnii. Using my fingers as a director I slit up the uterus to the placenta, which I easily detected. The body of the

child was now fully exposed, lying in the second cranial position, I lifted it from the uterus, and by exerting some little force to overcome the suction brought to bear upon the head, removed a living male child from its dead mother. The cord was tied and cut as usual. The operation was attended with a very slight loss of blood, and that of a dark venous character.

The unusual shape of the child's head, born without any pressure having been exerted upon it, was quite noticeable.

The child is being fed on fresh cow's milk, diluted and sweetened, and at the present writing, October 15th, stands a fair chance of being raised. It makes the fourteenth child born of Mrs. C——, all of whom are living.

I will not inflict upon the reader any remarks upon the foregoing case, nor will I undertake at this time to give a *résumé* of previous operations of a similar nature, but would refer all who may be interested in the literature of the subject to the *American Journal of the Medical Sciences*, October, 1879; *American Journal of Obstetrics*, January, 1879; *Wiener Medical Wochenschrift*, No. 22, 1879; *British Medical Journal*, June 14, 1879; and to the *Index Medicus*, for more recent cases.

My thanks are due Dr. R. P. Harris, of Philadelphia, for kindly directing me in my search after statistics, etc., bearing upon my case.—*Medical Record*.

NEOPLASMS OF THE OVARY.—THEIR ÆTIOLOGY, PATHOLOGY AND PROPHYLAXIS.

BY O. S. RUNNELLS, M. D., Indianapolis, Ind.

[A brief synopsis of the following paper read at the last meeting of the American Institute and published in the July number of this Journal, having led to misconceptions and unwarranted inferences, we have deemed it but fair to

all concerned that the paper be reproduced in its entirety. *Editor.*]

In the animal kingdom, as in the vegetable, it is nature's manifest purpose that life shall go on without impediment to perfection of growth and maturity of age. Whenever a tree bears scar or blemish, or dies prematurely, it is clear that some force from without has been operating to produce it; that some animal, or insect, or storm, or poor supply of nutriment, is chargeable with the result. Whenever the human tree is mal-formed, or demented, or diseased and is falling short of physical rotundity and perfection, it is none the less clear that some one has blundered; that the forces of life have been turned from their ordained channels and that the result of their operations, consequently, is but a caricature or satirization of nature's intended perfect work.

The broad fact is, that the ills we suffer are of human manufacture and environment, are due either to willful disobedience of law, or ignorance of it, and are, therefore, even in our present state of knowledge, for the most part avoidable. It has taken the race a long time to come to even a general recognition of this truth, and it is likely to take other ages to utilize the knowledge possessed, and to trace and fix the guilt of the responsibility. Man is so stupidly and willfully ignorant! How many ages has it been since the discovery was made that "the sins of the fathers are visited upon the children, even to the third and fourth generations?" And yet the most of men persist in "living unto themselves," in losing sight of the far-reaching consequences of their acts, and in being satisfied if they can half convince themselves that a given indulgence does not hurt *them*. What a glorious thing it would be for mankind if the results of bad indulgences could be limited to the first generation; if every transgressor were forced to meet in his own person the aggregate consequences of his acts? In that case his stupid wits would be quickened, and he would

cal existence of his children and children's children or to their disease and death. That a perfect title to all the physical possession is transmitted; that in germ at least the weaknesses and tendencies to disease of any individual will be found in his progeny and require only to be supplemented by favorable conditions to hatch; and that many germs supposed to be benign—the result of practices supposed to be void of evil influence—develop in succeeding generations into disease, the continuation of the like questionable practice proving the sure incubator. The contaminating, polluting and paralyzing influences made hereditary by parental indulgence should be further defined as anything that can establish disturbance of nature's equilibrium, or that can produce aberration of the life forces. Whatever can weaken or paralyze or render less responsive to the voluntary or involuntary demands of the life of any organ or organism, must be counted on to cripple and destroy the life that now is and that which is to come. Whenever any individual is in the grasp of a drug; is conscious of a demand in his system for any-narcotic, such as opium, alcohol, tobacco, coffee, tea, or the like, and is driven here or forced there by the craving of appetite for any non-nutritious substance, it must be recognized that he is a *physical bondsman*, and is not in possession of his powers. That in the recesses of his nature he is crippled, dwarfed, paralyzed; and is utterly incapable of giving off a perfect specimen of moral and physical life.

Whenever an individual's life-stream has in the recent past been *running through bad ground*, and is loaded with syphilis, consumption or other *hereditary debris*, it must be counted upon to *land it upon the exposed points below!*

Whenever male and female tamper with the procreative function and use it for purposes of mere sexual gratification—calling in all the aids of the devil's genius to prevent conception, and resorting to foul endeavor to destroy the new life if perchance it has gained foothold—they conspire

to bring damnation not only upon their own guilty organs, but upon the soul and body of the thus begotten!

Well may the poor mortal thus accidentally generated and enfolded in the coils of a physical or moral boa-constrictor bewail with King David, "In sin did my mother conceive me!"

All individuals thus accoutered should stop short and take their bearings. They should at once cease their miserable palaver of apology for, and defense of, their destructive habits and short-comings, and should take advice as to how henceforth they must deport themselves; as to how they may join their powers to the great forces in the world that "work for righteousness," and but for which man would have perished long ago. Thus it can be that, more and more, man shall get a fair start in the race of life, and be able during its progress to avoid the physical pitfalls which are now so prevalent. Thus it shall be that the lineage of effects as expressed in diseased conditions shall be better understood; the ætiology of diseases simplified, and both rendered more and more uncalled for through the operations of prophylaxis.

Confining our attention now to the morbid growths of the female genitals, particularly of the ovaries, we are able to fix more definitely the place in the scale of gradation, or rather degradation, which they occupy. We are able to see through the broad facts before enumerated; how the body in these growths retains vividly the memories of its past; how they are bound up with and explained by their antecedents, and how—though pathologists have so far failed to see all the links of their chain, thereby leaving us in much confusion—they are but deviatians of normal forces and the inevitable result of what has previously occurred.

It is nature's chief work to build up, to not only develop and maintain structure, but when hampered by impediments or thrown from her order by inimical forces

to accommodate her diverted powers in reparation and rebuilding. Some of the phases of this process are now clearly recognized. "Nothing," says Creighton, "marks so generally the disease-incidents of life as crudity or recrudescence in the activities of cells, tissues, organs and mechanisms. In other words, we shall find much in pathology to show that when the organism goes wrong, it retreats to broader ground, or reverts to modes of life through which it has come. There is a repetition of the incidents in the original embryonic development of structure and function—a reversion into the embryonic elements."

Even in the normal functional and structural processes of the mature body there are evidences of this reversion to embryonic modes of life—as is shown in the placenta—an entire organ built up anew for the intra-uterine nourishment of the child, and as is shown, also, in the development of the breast for the child's nourishment after birth.

This principle of return to embryonic characters—to rudimentary forms of cell-life—is one of the most fundamental facts in the process of disease, inasmuch as it affords a kind of insight into the genesis of tumor growth and the *modus operandi* of their modification through the agency of vitiated blood constituents. We are thus enabled to catch sight of reasons why tumors eventuate in malignancy or preserve a benign course.

It is immaterial to this discussion whether we hold with Cohnheim, that the tumors of the body are due to awakened growth of small centres, or foci, of embryonic tissue which have remained over from foetal development and which persist in their embryonic characters, while all else around them has assumed the characters of maturity; or whether we agree with Creighton that these "embryonic foci" not having been shown to exist in the organs generally, the growths result from an indwelling power of all the meso-blastic tissues to revert to embryonic characters

through the memory and spontaneity of development that is deeply rooted in them; or whether we admit, as we must, the partial truth of each of these claims, the result is the same. It is certain that we have in all neoplasms a development along the line of erratic impulse and in the course of an indwelling spontaneity. And that this development is in general expression like that operating in the renovation and repair of diseased and broken tissue, and like that, also, which is displayed with such originality in placental and foetal productions. It is all the great *vis-a-tergo* in life that was set to work for perfection. In the one case the force has been uninterfered with and is working according to design; in the other it has been counteracted and sent on a course at variance with its purpose. It is the illustration of the steam engine over again. When its noble powers are under the control of a competent and steady hand its performance is the perfection of usefulness, but when in the hands of an ignoramus or madman no language can picture the sad havoc it may work. It is but a quick transit to destruction.

Such is mal-performance of function as exemplified in ovarian neoplasms. It is the great life-force diverted. And nowhere are the conditions more favorable for fantastic expression than in the ovary, for this is just the tissue upon which the memories of development have been concentrated. Here the cells have been specifically charged with the recollection of the history of evolution. Here, the memories of the race are stored for reproduction. It is from the ovarian cell that the embryo grows in the perfect likeness of the parent. It is from this source that he gets his "instincts that can tell." But while it is clear that this lively memory is possessed by the ovarian follicle, it is none the less indisputable that the rest of the gland—the stroma—has it also to a greater extent than the mesoblastic tissue elsewhere. And that next to it in point of sensitivity stand the uterus and the mammae.

Thus it is that the ovarian cyst is but a perverted Graafian follicle; and every form of ovarian tumor but a developmental diversion of an embryonic capability. This is best epitomized in the dermoid cyst, where not only blood and bone, but teeth, hair, gland, muscle and nerve are produced as constituent parts. The dermoid cyst shows to the fullest extent the abilities of ovarian tissue in the process of neoplastic production. Here we have the surprising spontaneities of a collection of embryonic cells manifested—often feebly and grotesquely—in diverse ways side by side.

“When various kinds of structure,” says Creighton, “are thus brought together in their development, we have an evidence not only of an indwelling power of meso-blastic tissue to revert to embryonic modes of life, but also a common starting point for structures that come to be very unlike.”

With these facts of nature well before us, we can understand how sexual involution is one of the chiefest parts in the problem of pathology, and how essential to life is the right performance in regard to it. Knowing this, we are justified in demanding that the story of the sexual life shall be told and retold till the line of demarcation between the good and bad in sexual practice is made plain; till it is burned into the memories of all that the ovaries and sexual organs can not be divorced from the general bodily welfare, but must be the very first to suffer the stings and arrows of an outraged nature. Till it is recognized that during the menstrual life of woman the dominant influence is that emitted from the ovaries, and that every organ and function of her body is paying tribute to their welfare.

When this knowledge is embodied in the practices of the people, great care will be exercised that the nutrition of the ovaries be not crippled or perverted, and the processes of disease and degeneration be thus established.

ABSTRACTS.

MEDICAL SOCIETY OF THE STATE OF OHIO.

The transactions of The Ohio State Medical Society contains a few papers of interest from which we make brief selections. In a paper read by Dr. C. A. L. Reed on "Pelvic Hæmatocele," it was stated there was much of fiction in the common remark that there is no danger from the puncture of a trocar. He favored the evacuation of coagula, and thought that the demands of science and humanity called for some means of controlling the initial hæmorrhage. He believed that the operation by incision along Poupart's ligament, and the elevation of the peritoneum was a valuable procedure in cases in which the accumulation lay beneath the broad ligament. In view of the extreme probability of septic troubles we were justified in some simple expedient to control the initial hæmorrhage. This could be done by simple ligation of the vessels beneath the broad ligament. It was not the serious operation it had been pictured. Among the papers following this, the most interesting was that read by Dr. Palmer on "*A Rare Complication In Ovariectomy*," in which he reported the following case:

"Miss —, German descent, blonde, of delicate organization, noticed at the age of nineteen, which was three and a half years ago, an abdominal enlargement. It was central, regular, and uniform. Later, when the tumor had arrived at about the size of the child at term, she consulted a physician. He, in consultation with another, diagnosed abdominal dropsy from Bright's disease and tapped her. The abdomen completely collapsed. The process repeated itself. She applied for relief at one of our hospitals, where the same diagnosis was made. She was here again tapped with the same result. Again she was tapped by a third physician. At each operation about a bucketful and a half

of fluid was drawn off. The tapplings, numbering eight in all, occurred between June 3, 1883, and October 30, 1884—seventeen months in all. The fluid was at no time especially thick.

“Her last attendant, Dr. John Kellar, suspecting that her true condition might not be ascites, asked the author to see the case with him. He found the abdomen immensely distended. Fluctuation was very distinct, superficial, and uniform. There was also dullness extending backward to an unusual degree. Lateral decubitus showed a slight change in the area of dullness. No fluctuation could be felt in the posterior cul-de-sac. The patient was very anæmic and feeble; pulse, 120 to 130 per minute; febrile movement was noticed each evening. The menses had been absent for six months, and the lower extremities were swollen and œdematous. No albumen was found in the urine. Diagnosis: Ovarian cyst of the unilocular variety. In view, however, of the former diagnoses, and the fact that there were some obscure points in the history and in the present physical signs, an exploratory incision was made. This confirmed the diagnosis. Her general condition was the most unpromising for an ovariectomy, and the hygienic surroundings were also unfavorable.

“The abdominal wall being opened, the cyst wall was found closely adherent in all directions to the abdominal walls. When these adhesions were broken up, as far as could be reached by the finger, a large amount of fluid began to flow through the abdominal opening. For the instant this was thought to be ascites, and the patient was about to be turned upon her side to aid in its evacuation, when the true source of the fluid was found to be two lacerated fringes which entered the interior of the cyst. This opening was directly opposite to a cicatrix in the abdominal wall, and had been made by the repeated tapplings. Through this some cystic fluid had doubtless flowed into the peritoneal cavity after some of these tapplings. Subsequently

its edges had been agglutinated by peritoneal adhesions to the abdominal walls. Two other and smaller openings were also found. The smaller openings were clamped with hæmostatic forceps, the larger plugged with a large-sized ovariectomy trocar, through which the cyst was drained. This was almost completed before it was attempted to detach the cyst from its surroundings. Adhesions were short, thick, firm, numerous, and uniform over whole anterior and lateral abdominal walls, also to the omentum, stomach, and colon.

"The pedicle to the right ovary was transfixed, and cut off about one inch from the seat of ligation, after which a wedge-shaped section was cut out of the fore end and the peritoneal edges were sewed together by a continuous stitch of catgut. This was the author's manner of dealing with the pedicle in his last five ovariectomies all of which terminated successfully; it possesses advantages against secondary hæmorrhage and septic absorption. Oozing was controlled, and the peritoneal cavity cleaned of all fluids. The abdominal cavity was closed with silk sutures without a drainage-tube. Strength was sustained by brandy hypodermatically.

"The operation left the patient in a forlorn condition, but she began immediately to improve. Fearing vomiting, all food was given per rectum. A low form of peritonitis occurred during the first week, attended with tympanites and dyspnœa; pulse, 140; temperature, 103° to 104° F. On the eighth day a fatal result seemed imminent. Two stitches were removed and a rubber tube inserted, removing eight or ten ounces of fetid serum. The temperature fell three degrees in two hours; all other bad symptoms improved accordingly. Convalescence a few days later seemed established, and recovery seemed certain, when another complication appeared. On the twelfth day a smell of gas with a fecal odor was noticed at the opening made into the abdominal cavity. The next morning a small amount of

fecal matter was seen and removed. A fecal fistula had formed. It seemed to communicate inwardly with the lower small intestine, and the external opening presented midway between the umbilicus and symphysis pubis. At first it discharged daily several ounces of fecal matter, and has continued to discharge since in quantities gradually diminishing and less offensive. The present quantity averages daily two to three teaspoonfuls.

"For two months the recovery has been complete, except for the fecal fistula. It is possible that this may close spontaneously. No treatment for the fistula has been undertaken, except the regulation of the diet and the use of a compass; surgical interference may yet be needful."

THE CURE OF INFANTILE PARALYSIS BY ELECTRICITY.

In a remarkable memoir on infantile paralysis, Dr. Dive (*Revue Mensuelle des Maladies de l'Enfance*, June, 1885) assigns to the action of cold an important part in the etiology of this morbid process. Out of one hundred and forty cases, which form the basis of this monograph, the author has, in thirty-seven instances, been able to find a direct causative influence in exposure to cold. In nineteen cases the disease occurred as a complication of typhoid fever; in nine cases it apparently was due to some inherited nervous defect; in three cases the parents were intemperate; and in the thirteen other cases the attacks were recurrent, without any distinctly determinable cause.

The author believes that the best means of treatment consists in the application of electricity, combining the galvanic currents with the faradic, although the galvanic currents alone may be successful in the production of a cure, provided treatment commence in the earliest stages of the disease. It is necessary to make use of a battery with constant current and feeble chemical action, and to pass the current down the spinal cord, so as to act on the seat of the

lesion, which resides in the anterior horns of the spinal cord. This mode of treatment must be persisted in for several weeks, and then the paralyzed and atrophied muscles subjected to the action of the faradic current, while, during the same sitting, the positive pole of a constant current is placed on the vertebral column, at the seat of the lesion, and the negative pole on the path of the nerve, passing to the atrophied muscles. Finally, during the last three minutes the continuous current must be passed through the vertebral column. The applications should be made on alternate days.—*The Therapeutic Gazette*.

UTERINE HYDATIDS.

Mrs. M—, 35 years of age, multipara, entered St. Peter's Hospital, June 16, 1884, with the following history: Until about three months before her admission to the hospital she enjoyed good health. At that time, when she supposed that she was three months pregnant, a profuse hæmorrhage from the vagina occurred, accompanied by severe abdominal pain, and she was confined to her bed. Her health gradually failed after this, and she suffered from nausea and vomiting. There were occasional hæmorrhages, but not profuse. When I saw her in the ward of the hospital she looked pale and emaciated. She had not been able for many days to retain any food. The pulse was about 100, the temperature normal. Examination of the abdomen enabled me to appreciate the size and relation of the uterus. The uterus was considerably enlarged, and reached to the umbilicus. Vaginal examination did not reveal anything of special importance, beyond the fact that the cervical canal was dilated sufficiently to permit of the introduction of a finger as far as the os internum. There was obscure fluctuation in the uterus. Nothing resembling a child could be detected by abdominal palpation. Heart sounds were absent. The sign of ballottement was not present.

After trying many remedies for the vomiting, without avail, I advised the house physician to administer milk and beef tea by the rectum. For a week the nutrient rectal injections were employed. At the end of a week the patient was able to retain peptonized milk in the stomach. The rectal injections were omitted, and before leaving the hospital the patient was able to retain considerable food. At her own request she was permitted to leave the hospital. Two or three weeks later her husband came to my office and informed me that she had suddenly experienced severe pain in the abdomen, began to flow profusely, and before a physician could be summoned expelled a large number of cysts. The patient recovered. During the time that this patient was in the hospital there was no hæmorrhage, and the vaginal discharge did not exhibit any important features. —*Albany Annals.*

POST PARTUM DRAINAGE OF UTERUS.

It occurred to me a year or so ago that the lying-in-patient was particularly liable to septic trouble by reason of the position usually occupied in bed making anything like thorough drainage nearly impossible. At the same time probably, most of us, have been averse to the patient arising even to urinate, preferring them to use the bed-pan, and under these circumstances how easy it is for some of the discharges being thrown off the uterine walls to remain inside the uterine cavity. Of course the fundus of the uterus does not immediately sink below the sacral rim, yet when the patient is lying horizontal, the incline from the interior of the uterus to vagina is not great, and I fear too often nearer the dead level than is consistent with running streams. With this in view, whether fully justified or not, I have been in the habit of late of ordering the head of the bed blocked up from six to eight inches, or just avoiding what might be uncomfortable to the patient, and maintaining this position so long as she keeps her bed, and

there is any considerable lochial discharge. It is well also to permit these patients to be placed on the chamber once a day, to still further promote the escape of the offensive material from the uterine cavity.

WASHING THE NEW BORN CHILD.

We are also too apt to forget that the infant just brought into the world, was but a moment before enjoying the equatorial climate of $98\frac{1}{2}$ deg. F. or 37 deg. C., and that the one into which it is ushered is oftener 65 deg. F. than else. Under these circumstances a sudden change of $33\frac{1}{2}$ deg. of temperature takes place in its surrounding medium, and could these poor "little men or women" reason at this time, they would undoubtedly agree with the sentiment that "this is a cold, cold world." What should a consideration of such plain facts teach us? Plainly it seems to me, that we should wrap up the child very warm, and allow it to remain unexposed to the free atmosphere of the room until several hours have elapsed, in order to give its organism time to adapt itself to the extreme change in its environment, and thereby avoid many troubles which arise in consequence of this terrible first ordeal, through which the new being has to pass. I incline to the opinion that any other plan is almost cruel, and possibly one which might well be taken in hand by the humane societies, when they lack objects upon which to exercise their humane faculties.

EMMON'S OPERATION.

1. It is evident that the operation has been performed unnecessarily for symptoms similar to but other than those arising from lacerations of the cervix. Further, that it has been done imperfectly, even without preliminary treatment, in many more; and the failure to give relief as reported by several, is due to these two causes.

2. That from our present knowledge we cannot, at this time, arrive at any definite conclusion, from the fact that

many of the so-called consequences of lacerations of the cervix uteri are not settled beyond doubt.

3. That every one engaged in this department should carefully select his cases, and try every known means to give relief before recourse is had to operation.

4. The operation should never be performed *eo ipso* in cases of simple fissures or lacerations of first and second degree.

5. In cases of aversion and disease of the cervical or corporal cavity, or both, although attended by hyperplasia and displacement, it has been observed that all the symptoms abated and the parts returned to their natural condition, and that no laceration was discoverable after alleviative measures were instituted first, which alone caused the parts to return to a normal condition.

6. There are some cases of extensive laceration of cervix that seldom give rise to any inconvenience, and that, therefore, an operation should be deferred until symptoms arise that will call for its performance.

7. The operation, although indicated, should never be performed until, by preparatory treatment, the parts have been brought into a healthy condition.

8. Near, and during the climacteric period, the operation should be postponed as long as possible, and the patient not exposed to any risks, since in many cases all the symptoms subside under proper treatment, and never return under senile involution.

9. The operation is justifiable in cases of lacerations of the third and fourth degree without complications, if there is a history of malignant disease in the family.

10. The operation may be performed with perfect propriety in young women, as a preventive, if the laceration is bilateral and extends up to the cervico-vaginal junction, or beyond it even though there are no pathological changes; indeed it seems to be the duty of every one who observes a lesion to that extent, to urge the operation.

11. The operation is justifiable in any degree of laceration, and in rare instances even in fissures, when there exist cicatricial tissues productive of reflex disturbances, annoying in character, and not tractable to any other treatment.

12. The operation is absolutely indicated in all extensive tears of the os, or in which the cervix is everted, its mucous membrane and Nabothical follicles diseased, and especially if there be granular or cystic degeneration present, provided the parts have first been restored to a healthy condition by palliative treatment.—*Peoria Medical Monthly*.

HYSTERIA, ATTACKS OF TETANY, INDUCED BY PRESSURE ON THE OVARY.

E. L., a woman aged 27, was admitted into the Queen's Hospital, February 23d, 1885, suffering from paraplegia. She was markedly hysterical and had the characteristic "facies hysterica." While in the hospital she suffered from globus, clavus, dyspnœa and flushings of the face. At times also she had photophobia.

There was marked ovarian hyperæsthesia, and firm pressure over either ovary at once produced flushing of the face, a painful sense of fulness in the throat, and choking, quickly followed by rigidity of hands and feet, the hands assuming the characteristic posture observed in tetany. The legs and feet were strongly extended, the big toes showing a tendency to be flexed. Trismus was also brought about at the same time. The rigidity quickly passed off after discontinuance of the pressure. On one occasion catalepsy was present, the limbs maintaining any position in which they were placed for a considerable time.

The treatment consisted in isolation, blistering over the situation of the ovaries, and Faradization. The patient when discharged could walk well, and had lost the ovarian tenderness; no symptoms were produced by pressure.

The above case, which Dr. C. W. Suckling reports in the

London Medical Times, June 13, is very instructive and possesses much practical interest, in so far as it will serve to remind us that in very many of those mysterious and illy-defined hysterical conditions so often noted in women, the ovaries are at fault; it reminds us that we should look to and direct our treatment to these little organs. Pressure over the ovaries will often serve to unravel hitherto mysterious cases.—*Medical and Surgical Reporter*.

DISCONTINUANCE OF VAGINAL INJECTIONS AFTER LABOR, IN GERMANY.

Dr. Cushing writes from Berlin that vaginal injections after normal labors are now abandoned in all the institutions of repute in Germany. Men of such eminence as Schroeder, Gusserow, Winkel, Aaman, etc., who at one time used them have now abandoned them, not only on account of the injury which they sometimes did, but in consequence of the great success of the prophylactic means employed *ante partum* rendering them unnecessary, mortality after child-birth now having been reduced to a very low figure, indeed. The system of prophylaxis employed is as follows: After a bath and scrubbing of the body, especially the genitals, with soap and water, the vagina is thoroughly douched with a solution of corrosive sublimate of 1 to 5,000, and the external parts and ostium vaginæ are washed with one of 1 to 1,000. Whenever during labor repeated digital examinations are made, the douche of 1 to 5,000 is used again. Toward the end, the vulva is well anointed and corrosive sublimate in glycerine 1 to 1,000. The woman is delivered on her side, according to the English mode, introduced by Prof. Gusserow, and the cord is not tied until pulsation is faint or ceases. When the placenta is not discharged spontaneously, it is squeezed out by Crede's method, ergot is given and the vagina is well washed out with the 1 to 5,000 solution. If there has been an operation the uterus is also

washed out with this. The vulva is then washed out and soused with the 1 to 1,000 solution. After this there is no more vaginal douching, external cleanliness and daily washing the vulva with the 1 per 1,000 solution sufficing. The most scrupulous care is taken to prevent infection by nurses and doctors during delivery, a real scrubbing of hands and arms up to the elbows being insisted on both before and after delivery; and in examinations per vaginam and deliveries the hand is always first put in the 1 per 1,000 solution. It is then not dried, but oiled while still wet.—*North-western Lancet*.

THE PRODUCTION OF PHANTOM TUMOR.

The *London Medical Times*, June 13, 1885, says that Dr. Krukenberg, of Bonn, contributes to the *Archiv fur Gynaekologie* (Band xxiii. Heft 1,) an article on this subject. In a case of the kind under his own care—a case, that is, of apparent enlargement of the abdomen, which disappeared entirely when the patient was anæsthetized—he examined the patient very carefully to find out how the swelling of the abdomen was produced. He came to the conclusion that it was due to lordosis of the vertebral column, this lordosis being dependent upon weakness of the spinal muscles due to anæmia and debility. By the lordosis, he thinks, the space in the abdominal cavity is lessened, hence the pressure within it raised, and the anterior abdominal wall thrust forward by the pressure of its contents. Acting upon this theory of the disease, Dr. Krukenberg treated the patient by keeping her at rest, with pillows, etc., so arranged as to support the pelvis, and thus counteract the lordosis; under this treatment the abdominal protuberance disappeared. He candidly admits that his theory does not account for the persistence of the apparent tumor in such cases where the patient is lying down, unless hysterical contraction of muscles be assumed; nor, we may add, does

he explain why phantom tumors are not a regular accompaniment of the lordosis due to progressive muscular atrophy, a condition which suggested to him the theory that weakness of the spinal muscles was the cause of the disease in his case.—*Northwestern Lancet*.

THE FIRST DAY'S DAIRY OF A BABY.

2 A. M. Born a few minutes ago. Yelled.

2:15. Am washed. The fool doctor told 'em I was a boy just as if that was something new. Was whacked over the lap of a dizzy old Christmas card of a nurse who proceeded to tog me out in some bandages and a quarter of a mile of skirts. Kicked.

3:00. Have slept somewhat. The gorgeous old valentine made for me when I stirred, turned me into nineteen different positions. Must be training me for a contortionist. Yelled.

4:00. Have worked the sound wave for a straight hour. The old man isn't looking as happy as he did. I am a high soprano, I know, for I just heard some one in the fourth-story swearing. Old man has remarked that I'll depreciate property for four blocks.

4:10. Everybody is sitting around. The old man has just gotten even with the doctor by giving him one of his cigars. The doctor will have to charge himself up with a prescription pretty soon.

4:11. Told you so! The doctor has just asked the old man if he had ever matched one of his cigars against a glue factory. Yelled in sympathy.

4:15. The amiable old Easter memorial is working a bottle. She saw me watching her and said I was a tootsy-wootsy. I wish I were a shoesy-bootsy, I'd fix her for getting a corner on the family supplies and stowing them away in her stomach.

4:18 to 5:18. Yelled.

5:20. The antique circus-poster fed me on warm water and whisky. She said I had the colic. Will work the colic racket again.

6:00. Wazzer mazzar wiz ev'body? Giddy old chromo wiz two heads whackin' me on the back. Had colic twice.

9:00. Woke up with the headache. The old man ought to keep better goods. Guess I'll yell.

9:15. Am washed. Feel a little rocky. Ten minutes for refreshments, then I intend to do the colic gag over again for a cocktail.

10:00. Old man is writing telegrams about me. He looks a little like a last year's bird's nest himself. Yelled.

12:00. Have been asleep. Woke up suddenly and saw the venerable night mare they've hired to groom me, working her jaws over enough lunch to feed a shift of section hands. The old man oughtn't to allow it. What'll I do when he kicks out if this waste continues? The thought made me so mad that I yelled.

3:00 P. M. Have dozed. Everybody is doing well but the people in the block who are tired out for want of sleep. Old man has confidence in me. He has just said that he'd back my lungs against any steam whistle in town, best two toots out of three. It makes one proud to have the approval of his parents.

5:00. I was put on a pillow in a chair a few minutes ago, and a fool girl came in and sat down on me. Yelled.

5:20. Colic. Fortunate results; sleep.

8:10. Going to sleep for the night. The giddy old obelisk is in the chair snoring. Room sounds like a round-house. Mighty dull sort of a day. Good night.

DEATH FROM THE COLD DOUCHE.—From the *Weekly Medical Review* we clip the following interesting and instructive case, by L. C. Armstrong, M. D., Taylorville, Illinois: "On the 28th of January, 1885, Mrs. S., a widow 23 years of age, pregnant in the fifth month with her second

child, met her death under the following startling circumstances. On the afternoon of the above date Mrs. S., while entirely alone, took advantage of the absence of her parents to try what virtue there might be in the cold douche when directed against the os uteri, toward producing an abortion. She had a few days before expressed to her sister the desire for riddance from her present condition, wishing to be delivered of the child in utero. For two hours her parents were absent on that afternoon, from 3 to 5 o'clock. On their return, they at once on entering the house missed their daughter, Mrs. S., in whose care they had left their home during their absence. On making search for her they sought her bed-chamber; finding the door locked an entrance was forced. A sad sight met their gaze. There lay the dead body of the daughter whom they had left in perfect health not three hours before. Between her limbs was a basin of cold water in which lay a Davidson syringe. No post-mortem examination was made, but the testimony before the coroner and jury proved very clearly that no drug had been taken. It was evidently a case of death from shock produced by the stream of cold water thrown with criminal intent into the vagina and against the congested os of a pregnant uterus. The patient was an extremely healthy lady who had suffered but little in her first labor, and that this strong constitution should so suddenly succumb to the cold douche should indeed be a warning to women of the danger in the use of so simple an instrument as the Davidson syringe."

BOOK REVIEWS.

HOW TO TAKE CARE OF THE HEART. E. M. Hale, M. D., Chicago. Gross & Delbridge.

The author of this neat little brochure has already achieved so well deserved a reputation, as a writer, that our modicum of praise will add but little to his record. As a popular treatise on the hygiene of the heart, the book deserves to be a favorite with the public, and to young people especially, who in the "hey-day" of

life devote so little time to laying by a stock of vigor against the time of decline, we commend its lessons of moderation. The neat appearance of the work with its adaptability to the pocket, also adds to the favor with which it should be welcomed by the laity. But aside from its nature as a popular treatise, the semi-scientific discussion of the heart in health and disease, renders it a book that we welcome to our shelves as a means of reference on some few points not to be found elsewhere.

L. & B's PHYSICIAN'S VISITING LIST 1886. Blakiston, Son & Co., Phila.

We have received a copy of the above visiting list for 1886. It presents a somewhat neater appearance than their last issue. These pocket visiting books are becoming popular with the physicians.

"SHALL THE HOMŒOPATHIC SCHOOL REPRESENT TRUE PROGRESS IN MEDICINE?" By M. O. Terry, M. D., President of the Homœopathic Medical Society of the State of New York.

This little monograph, of some twenty-four pages, is simply the *personal* views of the author, and of course, represents *his own* opinions of the great question of therapeutics in our school. In running through the pages we find much to admire in the manner the writer has when expressing himself on certain issues of the day, but like many young men in the profession, "he will be older in a few years." The doctor apologizes for some of his references by adding, "my aim in referring to this matter, is simply to draw your attention to these inconsistencies. Let us be fair and bold to discharge our duties, even though we trample upon some of our inherited ideas." Life is too brief and too full of cares for us to more than add, beware doctor, of your arguments; they are susceptible of crude, as well as minute dissection, and as fallacious as the enticing songs of the mythical siren.

THE SCIENCE AND ART OF MIDWIFERY. By Wm. Thompson Lusk, A. M., M. D., New York. D. Appleton & Co.]

Verily the succeeding editions of Lusk's Midwifery come and go with almost annual regularity. At this day and age there need be a very great demand or very great merit to call forth the third edition of any medical work in less than four years time. With works like Playfair and Cazeaux already occupying the field, merit must certainly have something to do with the rapid sale of this work; and that it has already found its way into the hands of French, Italian and Spanish translators, speaks for itself. The author says in his preface: "The activity that has prevailed in the study of obstetric phenomena, and in the perfecting of obstetric

